Davis Behavioral Health

934 South Main Street, Layton, UT 84041 (801) 773-7060

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Name:		Date of Birth:		
Address:		S	SN: Zip Code:	
City:		State:	Zip Code:	
Former Name: Phone Number:				
By signing this by Davis Beha	Authorization, I authorize the avioral Health, Inc. (the "Prov	vider") to the recipient(s) named	I ally-identifiable health information maintained below. I also expressly consent to the osed by me to a mental health therapist.	
	formation may be disclose (s) (the "Recipient"):	ed under this Authorizatior	n to the following individual(s) or	
Print Name or Org	ganization			
Print Address, City	y, State, Zip Code		Print Phone Number	
another hea past, preser services. Ar about treatn	alth care provider, a health plan, m nt or future physical or mental hea ny provider that operates a federal ment for alcohol or drug abuse with	ly employer, or a health care clearir Ith or condition, the provision of my Ily-assisted alcohol or drug abuse p	vider, or information received by the Provider from inghouse. Health information may relate to my health care, or payment for my health care program is prohibited from disclosing information on unless a disclosure is otherwise authorized by Records (42 CFR, Part 2).	
SECTION B:	SPECIFIC INFORMATION	ON TO BE RELEASED:		
☐ Psy	chiatric Evaluation/Assessment		☐ Discharge Summary	
☐ Treatment Plans ☐ Progress Notes ☐ Medication History			☐ Alcohol and Drug Records ☐ Other:	
Please choo	se one of the following:			
 ☐ I authorize only copies of records to be sent (<u>immediately</u>) to the person(s) listed in Section A. ☐ I authorize only verbal communication with the person(s) listed in Section A. ☐ I authorize both verbal communication and copies of records (<u>to be sent immediately</u>) to the person(s) listed in Section A. ☐ I authorize both verbal communication and copies of records (<u>to be sent only upon my further notice</u>) to the person(s) listed in Section A. 				
SECTION C: The purpose(s) o	PURPOSE OF THE USE of this Authorization is (are):	OR DISCLOSURE		
•	Continuation of care.			
•	Specifically, the following purpor	se(s) :		
•	disclose its purpose. Note: Th		ated by the Client and the Client does not elect to the information to be used or disclosed pertains atment.	

SECTION D: EXPIRATION

This authorization and consent is subject to revocation at any time except to the extent that Provider has already taken action in reliance on it. If not previously revoked, this consent will terminate at the end of treatment with DBH, unless otherwise noted here: _____

SECTION E: OTHER IMPORTANT INFORMATION

- 1. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Provider, except when I am (i) receiving research-related treatment or (ii) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from Provider.
- 2. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Provider's Privacy Office. The address of the Privacy Office is 934 South Main Street, Layton, Utah, 84041.
- 3. This paragraph is only applicable to certain Authorizations to disclose health information for marketing purposes: I understand that Provider may, directly or indirectly, receive remuneration from a third party in connection with marketing activities undertaken by Provider.
- 4. . Provider hereby binds itself to safeguard the records and not re-disclose any medical records in violation of law.
- 5.. I understand that the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records.

 (42 CFR. Part 2). Any authorized disclosure of drug or alcohol treatment information will be accompanied by the following notice:

Davis Behavioral Health Substance Abuse Redisclosure Notice PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

- This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.
- This information has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose.
- The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumer.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client signature:	Date of signature:			
Print client's full name:				
Staff Member/Witness Signature:	Date of signature:			
Relationship to client:				
*When client is not able (e.g. incompetent) to give consent, the signature of a parent, guardian, or other authorized legal representative is required.				
Signature of legal representative:	Date of signature :			
Print legal representative's name:	Relationship to client:			