Davis Behavioral Health
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Name: _____ Date of Birth: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip Code: _____
Former Name: _____ Phone Number: _____

SECTION A: USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the use and disclosure of my health information maintained by:

NAME OF PERSON OR ORGANIZATION SENDING THE INFORMATION

_____
Print Name or Organization

_____
Print Address, City, State, Zip Code Print Phone Number

To be sent to (check one):

_____ Davis Behavioral Health, Layton Office ATTN: _____
2250 North 1700 West
Layton, UT 84041
(801) 773-7060

_____ Davis Behavioral Health, Main Street Office ATTN: _____
934 South Main Street
Layton, UT 84041
(801) 773-7060

SECTION B: SPECIFIC INFORMATION TO BE RELEASED

- ☐ Psychiatric Evaluation/Assessment
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Medication History
- ☐ Discharge Summary
- ☐ Substance Use Disorder Records
- ☐ Labs
- ☐ History and Physical
- ☐ Other: _____

SECTION C: PURPOSE OF THE USE AND DISCLOSURE

- ☐ Coordination of Care
- ☐ Patient made this request and does not want to state purpose.
  Note: This box may <u>not</u> be checked if the information relates to substance use disorder services.

- ☐ Other: _____

SECTION D: EXPIRATION

This Authorization will stay in effect until my discharge from treatment, unless I write another date or event here: _____

I may revoke this authorization at any time by delivering <u>written</u> notice to the front desk of any DBH facility or by mailing my notice to the Medical Records Office – HIPAA Specialist at 934 S Main Street, Layton, UT 84041. However, my revocation will not have effect on any action taken by DBH before they received my <u>written</u> notice.

SECTION E: OTHER IMPORTANT INFORMATION

- Health information includes personally identifiable and protected health information as defined by applicable privacy regulations, including "Confidentiality of Substance Use Disorder Patient Records" and the "Health Insurance Portability and Accountability Act."
- I may choose to not sign this Authorization and it will not prevent me from getting treatment at DBH.
- DBH cannot guarantee that the Recipient will not re-disclose my health information. The Recipient may or may not be subject to privacy regulations. Any authorized disclosure of health information relating to substance use disorder services will include the following notice:

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

- This notice accompanies a disclosure of information concerning a patient in a substance use disorder treatment program, made to you by authorization of such patient or as otherwise permitted by federal regulations.
- Federal regulations prohibit you from making any further disclosure of this information unless authorized by the patient or otherwise permitted by 42 CFR Part 2.
- A general authorization for the release of medical or other information is **not** sufficient for this purpose.
- Federal regulations restrict any use of the information to criminally investigate or prosecute any patient of substance use disorder services.

I have read, understood, and had opportunity to ask questions about the terms of this Authorization.

Patient signature:_____ Date of signature: _____

Print patient's full name: _____

Staff Member/Witness Signature: _____ Date of signature: _____

Relationship to patient:_____

If patient is unable to sign this Authorization (e.g. incapacitated), the signature of a parent, guardian, or other legal representative is required.

Signature of legal representative: _____ Date of signature:_____

Print legal representative's name: _____ Relationship to patient:_____