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: ______________________________ SSN: ____________________
City: ____________________ State: __________ Zip Code: ____________________
Former Name: ____________________ Phone Number: ____________________

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, **I authorize Davis Behavioral Health, Inc. (the "Provider") and the following parties to communicate with and disclose to one another my individually-identifiable information specified in Section B**. I also expressly consent to the disclosure by Provider and its therapists of any confidential information disclosed by me to a mental health therapist.

Print Name of Individual/Organization and Contact Information

Hospital/ER Staff Intermountain Layton Hosptial
Address 201 West Layton Parkway, Layton UT 84041
Phone # 801-543-6000

Primary Provider ______________________________
Address ______________________________
Phone # ______________________________

Family/Friends ______________________________
Address ______________________________
Phone # ______________________________

Other (name/org and relationship): ______________________________
Address ______________________________
Phone # ______________________________

Other (name/org and relationship): ______________________________
Address ______________________________
Phone # ______________________________

Health information includes information collected from me or created by any of the Parties or information received by the Parties from another health care provider, a health plan, my employer, or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services. Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

SECTION B: SPECIFIC INFORMATION TO BE RELEASED:

- ☐ Psychiatric Evaluation/Assessment
- ☐ Discharge Summary
- ☐ Treatment Plans
- ☐ Alcohol and Drug Records
- ☐ Progress Notes
- ☐ Medication History
- ☐ Other: _______________

Please choose one of the following:

- ☐ I authorize **only** copies of records to be sent (immediately) 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 (to be sent immediately) to the person(s) listed in Section A.
- ☐ I authorize **both** verbal communication and copies of records (to be sent only upon my further notice) to the person(s) listed in Section A.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are):

- Continuation of care.
- Specifically, the following purpose(s) : ___________________________________
- This request for information to be used or disclosed has been initiated by the Client and the Client does not elect to disclose its purpose. ***Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.***

SECTION D: EXPIRATION

This authorization and consent is subject to revocation at any time except to the extent that any of the above-named Parties 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: ___________________

Insert applicable event or date – mm/dd/yy) *Note: If an expiration event is used, the event must relate to the consumer or the purpose of the use or disclosure.*

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 the parties, 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 the parties.
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 parties in reliance on this Authorization before written notice of revocation is received by the parties. I further understand that that I must provide any notice of revocation in writing to the DBH 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 the parties may, directly or indirectly, receive remuneration from a third party in connection with marketing activities undertaken by the parties.
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 parties cannot guarantee that a 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:

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: ____