AUTHORIZATION
To Use and Disclose Protected Health Information
*Required fields must be completed in order to process request.

*Client Name: ______________________________	*DOB: ________________
*Address: ______________________________	Home phone #: ________________
*City: ____________ *State:________ *Zip:________	Cell Phone #: ________________
Email: ______________________________	Work Phone #: ________________

Utah Healing Center follows Federal and State confidentiality regulations prohibiting release of your protected health information without your permission. We can provide you with a copy of our Notice of Privacy Practices. Substance Abuse treatment records have additional privacy protections (42 CFT Part 2). I understand that use and disclosure means sharing my medical records includes verbal and written communication. I give permission for Utah Healing Center and the person and/or organization listed below to share my medical (including prescription drug history), mental health, and/or substance use treatment records.

NAME OR OTHER SPECIFIC IDENTIFICAITON OF PERSON(S) AUTHORIZED TO RECEIVE/MAKE THE REQUESTED USE OR DISCLOSURE:

*Agency/Name: ______________________________	*Attention: ________________
*Address: ______________________________	*Phone: ________________
*City: ____________ *State____________ *Zip: ________	Fax#: ________________

***For what purpose are the records being released**______________________________

EXPIRATION: Date or Event ______________ or ONE year from the signed date, unless revoked.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

( )Admission ( )Discharge ( )Evaluations ( )Progress Notes ( )Medication Notes ( )Drug Tests
( )Diagnosis ( )Care Plan ( )Group Notes ( )Prescription History ( )Billing records
( )Treatment and/or Compliance ( )Other:______________________________

NOTE TO CLIENT: I understand I may revoke this authorization at any time. To revoke this authorization, I will need to send a written notice to Utah Healing Center. Verbal revocation will only be honored for drug and/or alcohol treatment records: Revocation will not include any information already shared in reliance upon this authorization. Signing this form is voluntary and not required in order to receive services at Utah Healing Center . I understand once the information is shared, it is no longer protected.

ACCESS TO MY RECORD: I understand I can request a copy of my record. This request will be reviewed and approved by my therapist. This can take up to 30 days to complete and charges may apply. I understand I can also review my records with my therapist by making an appointment.

*Client Signature	*Date
*Representative Signature	*Relation
*Representative Name (print)	*Date
*Witness Signature	*Date

UTAH HEALING CENTER CONTACT INFORMATION

Name: Utah Healing Center	Attention: ________________
Address: 5284 South Commerce Drive Suite C-134	Phone: (801)266-4643
City: Murray State: Utah Zip: 84107	Fax: (801)266-4775