Pediatric Care of Ogden
(801) 621-1701

Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:

Patient Name

Address | City | State | Zip

Phone Number | Date of Birth

This authorization is to release the protected health information from:

Name **PEDIATRIC CARE OF OGDEN** | Phone Number **(801) 621-1701**

Address **1740 COMBE RD SUITE 5** | City **SOUTH OGDEN** | State **UT** | Zip **84403**

Deliver by: ☐ Patient ☐ Mail ☐ Fax Fax Number : **(801) 210-7098**

This authorization is to release the protected health information to:

Provider | Phone Number

Address | City | State | Zip

The purpose of this disclosure is:

Release the following information:

Patient Health Information:

☐ Mental Health Therapy Records

☐ Complete Medical Record (excludes Mental Health Therapy record please specify above)

☐ Other records as specified________________________________

This Authorization will remain in effect:

☐ From the date of this Authorization or until the following event occurs: ____________________

Unless otherwise noted above this authorization will remain in effect until the patient's 18th birthday

I understand that:

- Once *"this facility"* discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to *"this facility"* to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR § 164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Management/Medical Record Department. If I revoke this Authorization, Pediatric Care of Ogden may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.
- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of *"this facility"* treatment of me.
- If I have questions about disclosure of my health information, I can contact the facility / clinic Medical Record Department, or call 801-621-1701.

Signature of Patient or Representative	Date
Relationship	Office Use