

## Authorization to Use and Disclose Protected Health Information

<b>Authorization to release the protected health information of:</b>			
Patient Name			
Address		City	State Zip
Phone Number		Date of Birth	
<b>This authorization is to release the protected health information to:</b>			
Name <b>PEDIATRIC CARE OF OGDEN</b>		Phone Number <b>(801) 621-1701</b>	
Address <b>1740 COMBE RD SUITE 5</b>		City <b>SOUTH OGDEN</b>	State <b>UT</b> Zip <b>84403</b>
Deliver by: <input type="checkbox"/> Patient <input type="checkbox"/> Mail <input type="checkbox"/> Fax Fax Number : <b>(801) 210-7098</b>			
<b>This authorization is to release the protected health information from:</b>			
Provider		Phone Number	
Address		City	State Zip
<b>The purpose of this disclosure is:</b>			
<b>Release the following information:</b>			
<b>Patient Health Information:</b>			
<input type="checkbox"/> Mental Health Therapy Records			
<input type="checkbox"/> Complete Medical Record (excludes Mental Health Therapy record please specify above)			
<input type="checkbox"/> Other records as specified _____			
<b>This Authorization will remain in effect:</b>			
<input type="checkbox"/> 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