



2295 S Foothill Dr. Salt Lake City, Utah 84109 Phone (801) 486-3021 Fax (801) 485-6339

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Current Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_ Patient Previous Name(s): \_\_\_\_\_

I. AUTHORIZATION

I AUTHORIZE THE ENTITY NAMED BELOW TO RELEASE MY HEALTH INFORMATION AS INDICATED BELOW (FROM):

Name (or Title) and organization requesting information from: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

TO USE OR DISCLOSE THE FOLLOWING HEALTH CARE INFORMATION (CHECK ALL THAT APPLY):

- All health care information in my medical record for the date (s): \_\_\_\_\_
- Health care information in my medical record relating to the following treatment or condition: \_\_\_\_\_

- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X Rays, bills), specify date(s): \_\_\_\_\_

YOU MAY USE OR DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS & TREATMENT FOR (CHECK ALL THAT APPLY):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

YOU MAY DISCLOSE THIS HEALTH CARE INFORMATION TO:

Name (or title) and organization sending information to: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

REASON(S) FOR THIS AUTHORIZATION (CHECK ALL THAT APPLY):

- My request
- Other (specify) \_\_\_\_\_
- Check only if FFC requests the authorization for marketing purposes
- Check only if FFC will be paid or get value for providing health information for marketing purpose

THIS AUTHORIZATION ENDS;

- When revoked in writing
- . 90 days from date signed
- on (date): \_\_\_\_\_
- When the following event occurs: \_\_\_\_\_

II. Patient Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by FFC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from FFC. Or,
- Write a letter to FFC.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. (Note: there is a charge for copying all records, including x-rays)

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Time

\_\_\_\_\_  
Photo ID and Number (FFC Personnel to Complete)

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative)

\_\_\_\_\_  
FFC Staff Signature