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 the use or disclosure of my individually-identifiable health information maintained by **Davis Behavioral Health, Inc. (the "Provider**") to the recipient(s) named below. I also expressly consent to the disclosure by Provider and its therapists of any confidential information disclosed by me to a mental health therapist.

☐

My health information may be disclosed under this Authorization to the following individual(s) or organization(s) (the "Recipient"):

_____
Print Name or Organization

_____

Print Address, City, State, Zip Code Print Phone Number

Health information includes information collected from me or created by the Provider, or information received by the Provider 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
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Medication History
- ☐ Discharge Summary
- ☐ Alcohol and Drug Records
- ☐ 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 Provider has already taken action in reliance on it. If not previously revoked, this consent will terminate in 90-days, 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 Provider, 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 Provider.

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 Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Provider's 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 Provider may, directly or indirectly, receive remuneration from a third party in connection with marketing activities undertaken by Provider.

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 Provider cannot guarantee that the 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:

Davis Behavioral Health Substance Abuse Redisclosure Notice
PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

- This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.
- This information has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose.
- The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumer.

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:_____

SUBMIT FORM & Photo ID