



Health Clinics of Utah
 Integrated Services for
 Children with Special Health Care Needs
 (IS4CSHCN)

Ogden Clinic
 2540 Washington Blvd.
 Suite 122
 Ogden UT 84401
 P (801) 395 6499
 F (801) 334-9804

Salt Lake Clinic
 168 N 1950 W
 Suite 201
 Salt Lake City, UT 84116
 P (801) 715-3500
 F (801) 715-3385

Provo Clinic
 150 E Center Street
 Suite 1100
 Provo, UT 84606
 P (801) 374-7011
 F (801) 374-7009

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

| | | | |
|-----------------|------|----------------|-----|
| Patient Name: | | Date of Birth: | |
| | | / / | |
| Current Address | City | State | Zip |
| | | | |

I _____ hereby authorize Health Clinics of Utah - IS4CSHCN
 (Patient/Personal Representative) 168 North 1950 West, Suite 201
 Salt Lake City, Utah 84116
 801-273-2988 801-272-3502
 (Phone) (Fax)

to disclose specific health information from the records of the above named patient to:
 _____ (Name of facility you are requesting records disclosed to)

The specific health information authorized for disclosure is (include dates of service): _____

The purpose of the disclosure is: _____

This authorization expires (check one): 1 year from the date of this authorization
 This is a one time disclosure
 Other _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I understand Health Clinics of Utah cannot condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

I understand I may refuse to sign and may revoke this authorization at any time by sending a written revocation of authorization to: Health Clinics of Utah Privacy Officer, 150 East Center Street Suite 1100, Provo, UT 84606. I understand the revocation is not effective to the extent that Health Clinics of Utah has taken action in reliance on this authorization.

I understand that information disclosed pursuant to this authorization may be redisclosed by recipient and may no longer be protected by the federal privacy laws.

 Signature or Patient/Personal Representative Date

If signed by Personal Representative, Relation to Patient: _____
 Copy provided to patient for their records.