PARK CITY VACCINES @ SNOW CREEK
1600 Snow Creek Drive • Park City, UT 84060
Ph (435) 655-0055 • FAX (435) 655-8979

Name _____ SS# _____ Birth Date _____

Former Names _____ Home #_____ Work # _____

Address_____ City_____ State_____ ZIP_____

AUTHORIZED TO RELEASE INFORMATION:

Person/Agency Name: _____

Address_____

City_____ State_____ ZIP_____

Phone #_____ Fax #_____

AUTHORIZED TO RECEIVE INFORMATION:

Person/Agency Name: _____

Address_____

City_____ State____ ZIP_____

Phone #_____ Fax #_____

Attention_____

INFORMATION TO BE DISCLOSED: I am requesting my health/medical records to be disclosed as indicated below. Please initial each section to be disclosed:

_____ Treatment Notes _____ Diagnosis _____ Medication Information

_____ Radiology Reports _____ Lab Results _____ Other _____

Substance Use Treatment Records: I am specifically authorizing release of substance abuse/chemical dependency treatment records, which are both contained within or separate from other health records: _____ (initial).

Purpose: I understand information checked or initialed above is being requested for the purpose of:

_____

REVOKE: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

EXPIRES: Unless otherwise revoked, this authorization will expire on the following date, event or condition:

Date_____ Event or Condition_____

If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

SIGNATURE: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

☐ I have been given a copy of this authorization. ☐ I have declined a copy of this authorization.

Client Signature_____ Date_____

Disclosure of a minor's substance abuse treatment records requires the signature of the minor and the minor's parent or authorized representative.

Authorized Representative Signature_____ Date_____

Printed Name of Authorized Representative_____ Relationship_____

Address of Authorized Representative_____ Phone #_____

Staff Member / Witness Signature_____ Date_____