Utah Department of
Health & Human Services
Family Health

Integrated Services Program

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Authorization to release the protected health information of (patient name):

Name: Date of Birth:

Address: Phone Number:

Authorize DFH to RELEASE protected health information TO named provider/entity: **_Patient/Legal Rep. Initials:_________**

Provider Name and Contact Information:

Name: Phone Number:

Address: City, State, Zip:

Authorize named provider/entity to RELEASE protected health information to DFH: **_(****Please send all information to address checked below)_** **_Patient/Legal Rep. Initials:_________**

□ Integrated Services Program
PO Box 144610
Salt Lake City, UT 84114-4610
Fax: 801-272-3502
Ph: 801-273-2988

Release the following information for Health Care Coordination purposes:

□ Admit/Discharge Summary
□ Birth/Newborn Records
□ Dental Records
□ Developmental Assessments/ IFSP
□ Feeding/Nutrition
□ Growth Charts
□ Hearing Screens/Tests
□ Vision Screening/Testing
□ Immunizations
□ IQ/Psychological Testing
□ Lab or Radiology Reports
□ Medical records
□ Newborn Screening Tests
□ OT/PT Reports
□ School Records/ IEP
□ Social Services
□ Speech/Language Assessments
□ Surgical Reports
□ Other Records as Specified: ______________________________

Dates of Service Requested:___________________

By signing below, I understand that:

1. This consent remains effective for **1 year** from the date last signed.
2. I may revoke this authorization at any time by giving written notice to:
   ISP Manager, PO Box 144610, Salt Lake City, UT 84116-4610
   Any actions already taken in reliance on this authorization will not be affected by my revocation.
3. Treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on whether I sign this authorization. If an exception applies, the consequences to me will be explained.
4. I understand once the information is disclosed, this facility 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 laws governing the use and disclosure of my health information.
5. I may make a request in writing at any time to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524.
6. A copy of this Authorization will be provided to me.

Print Name of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	If Signed by Legal Representative, Relation to Patient: