HEALTH
UNIVERSITY OF UTAH

PATIENT AUTHORIZATION

DISCLOSURE OR RECEIPT OF *PSYCHOTHERAPY NOTES*[1]

Patient Name _____ **Medical Record #** _____

Date of Birth _____ **Phone # (_____)**_____

Patient Address_____

_____

Soc. Sec.# _____ **(Providing your SS# is voluntary, but necessary to accurately identify your medical records Failure to provide this information will likely delay the processing of your request).**

Approximate Dates of Treatment: _____

1. I authorize the following health care provider or facility to **DISCLOSE** or **RECEIVE** my patient information:

_____ University Hospital (Inpatient) _____ University Neuropsychiatric Institute (UNI)

_____ Community Clinics _____ Sugarhouse Clinic _____ Madsen Clinics

_____ Moran Eye Center _____ University Orthopædics Center

_____ Huntsman Cancer Hospital _____ Huntsman Cancer Institute

_____ Outpatient Clinic(s):_____ _____

_____ Specific Provider(s): _____

_____ Other: Name/Credentials: _____

Phone:_____ Relationship: _____

Address: _____

2. Please disclose my psychotherapy notes.

3. Please indicate the purpose of the disclosure of your psychotherapy notes:

_____.

4. If applicable, I understand that based on the dates, providers, and information I have designated above, the disclosure UUHSC makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

5. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations,

[1] Note: This form is used only in very specific circumstances. Contact the HIPAA Privacy Office about its use.

and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that the University of Utah Health Sciences Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Medical Records, 50 North Medical Drive, SLC UT 84132

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (check one):

_____ 1 year from the date below _____ One time disclosure only _____ Other: _____

_____ _____
Signature of Patient or Representative Date

_____
If Applicable, Name of Personal Representative*

*Description of Personal Representative Authority:

☐ Parent ☐ Medical Power of Attorney

☐ Other, explain: _____ and attach documentation.

Signature must be verified by U of U Health staff or notarization may be required. When complete, place in patient's medical record.

- _____ _____ _____
  Signature of UUHSC Staff Member Printed Name and Employee ID# Date

- SUBSCRIBED AND SWORN before me this ____ day of _____, 20____.

NOTARY PUBLIC

Residing in _____

My Commission expires: _____

UUHSC Internal Use Only

☐ Staff Member Processing Request's Name and Employee ID: _____

☐ Date Received: _____

☐ Date Sent to Patient: _____

☐ A 30 day extension as been requested. Reason: _____

☐ Patient Notified of Extension On: _____

☐ Request Processed by (Name and Employee ID): _____

☐ Fee Charged (if any): _____