AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

Patient ID Number: _____ Phone Number: _____

AUTHORIZATION

In order to provide me with the most effective services and treatment, I authorize FourPoints Health to coordinate with, share with, and/or release confidential information to (check all that apply):

☐ Adult Parole and Probation	☐ Southwest Behavioral Health Center
☐ Central Utah Counseling	☐ Utah Division of Child and Family Services
☐ Indian Health Services	☐ Utah Department of Workforce Services
☐ Juvenile Court (including Probation),	☐ Social Security Administration
☐ Justice/District Court	☐ Other (complete information below)
☐ Paiute Housing Authority	Name: _____
☐ PITU Education Department	Agency: _____
☐ PITU Enrollment Department	Address: _____
☐ School or School District (Specify: _____)	City: _____State: ____ Zip: _____

TO RELEASE THE FOLLOWING INFORMATION

□ All information to assist with delivery of service, evaluation and/or treatment

□ Information relating to the following treatment, condition, or dates: _____

□ Other (specify): _____

NOTE: ANY REDISCLOSURE OF RECORD INFORMATION IS PROHIBITED BY FEDERAL REGULATION (42 CFR PART 2). I understand that my records are protected under the federal regulations governing Confidentiality of Client Information Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically thirty (30) days following case closure or as follows: _____

_____ _____

DATE SIGNATURE OF CLIENT

_____ _____

DATE SIGNATURE OF PARENT, GUARDIAN OR AUTHORIZED REPRESENTIVE

_____ _____

DATE WITNESS SIGNATURE