UTAH COUNTY HEALTH DEPARTMENT

YOU WILL RECEIVE A RESPONSE IN 2-3 BUSINESS DAYS FROM THE TIME WE RECEIVE YOUR FORM

PATIENT NAME: ____
Last First MI Maiden or Other Name

DATE OF BIRTH: ____________________

❏ **I authorize the release of information held by the Utah County Health Department (UCHD) to:**

NAME: ____

ADDRESS: ______________________________ CITY: ______________ STATE: _____ ZIP: __________

PHONE: ________________ FAX: __________________ EMAIL: __________________________

❏ **I authorize the release of information held by __________________________ to the Utah County Health Department (UCHD).**

Please send material to: Utah County Health Department
151 S University Ave #1610
Provo, UT 84601

Phone: 801-851-7025
Fax: 801-851-7055
Email: shirleyo@UtahCounty.gov

INFORMATION TO BE RELEASED:

	DATES		DATES
❏ History and physical exam	____________	❏ STD	____________
❏ Nursing Notes	____________	❏ HIV related information	____________
❏ X-ray reports	____________	❏ Incident/Short encounters	____________
❏ Immunizations	____________	❏ Other: ________________	____________
❏ Cholesterol	____________		

PURPOSE OF DISCLOSURE:

❏ Changing Physicians
❏ School
❏ Legal
❏ Consultation/second opinion
❏ Insurance
❏ Continuing Care
❏ Workers Compensation
❏ Personal
❏ Other (please specify): ______________

1. I understand that this authorization will expire **90 days** after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and that it will be effective on the date written notice is received (except to the extent of action taken prior to receiving the written notice).
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. By authorizing this release of information, I understand that my health care and payment for my health care will not be affected.
5. I understand that I may have a copy of the information described on this form and a copy of this form after I have signed it.
6. I have been informed that Utah County Health Department will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

______________________________________ **OR** ______________________________ __________

SIGNATURE OF PATIENT PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

______________________________________ ____________ ______________________________

PLEASE PRINT NAME DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: ______________________ BY: ____________________________

IDENTIFICATION PRESENTED: ____________________