Wasatch Pediatric Neuropsychology, Inc.
231 East 400 South, Ste. 335
Salt Lake City, UT 84111
p. 801.363.1189 f. 801.363.1196

Please send information Attn: Salem

Authorization to Use and Disclose Health Information

Authorization to release the health information of:

Patient Name	
Current Address City State Zip	
Phone Number ( )	Phone Number ( )	Date of Birth / /

This authorization is to release protected health information to:

Name Wasatch Pediatric Neuropsychology

Address 231 East 400 South, Suite 335 City Salt Lake City State UT Zip 84111

This authorization is to release protected health information from:

Name of Releasing Facility

Address City State Zip

Release the following information:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation(s)
- ☐ Operative report(s)
- ☐ Progress notes
- ☐ Emergency record(s)
- ☐ Pathology report(s)
- ☐ Radiology report(s)
- ☐ Lab report(s)
- ☐ Cardiology report(s)
- ☐ Psychiatric record(s)
- ☐ Treatment Plan(s)
- ☐ Alcoholic/Drug Treatment record(s)*
- ☒ Other records as specified: IEP, 504 plans, academic and intellectual Testing, health care plan, therapy reports

Reason for Disclosure:

Term: This Authorization will remain in effect:

☒ From the date of this Authorization until: episode of care

☐ Until the following event occurs: ______

Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.

BY SIGNING THIS AUTHORIZATION I UNDERSTAND THAT:

- Once the Releasing Facility discloses my health information by my request, it cannot guarantee that my health information will not be redisclose to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to the Releasing Facility or Wasatch Pediatric Neuropsychology to inspect and/or obtain a copy of my health information as provided in the Federal Privacy Rule 45 CFR §164.524).
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Releasing Facility. If I revoke this Authorization, the Releasing Facility may not be able to reverse the use or disclosure of my health information while the Authorization was in effect.
- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Wasatch Pediatric Neuropsychology, enrollment in any health plan, or eligibility for benefits, provided the information is not required to determine my eligibility to receive such treatment or benefits.
- If I have any questions about the disclosure of my health information I can contact Wasatch Pediatric Neuropsychology's Health Information Services or Medical Records Department.

*Alcohol/drug treatment records are protected by federal rule 42 CFR, part 2.

Signature of Patient or Legal Representative	Date
If Signed by Legal Representative, Relationship to Patient	Signature of Witness (optional)

Shaded areas for Office Use Only