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: _____

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		
Address	City	State Zip
This authorization is to release protected health information from:		
Name		
Address	City	State Zip

Release the following information:

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

Term: This Authorization will remain in effect:

☐ From the date of this Authorization until: _____

☐ Until the following event occurs: _____

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

I understand that:

- once "*this facility*" discloses my health information by my request, it cannot guarantee that Recipient will not redisclose my health information 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 *"this facility"* to inspect and/or obtain a copy of my health information maintained at this facility 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 Wasatch Pediatric Neuropsychology. If I revoke this Authorization, Wasatch Pediatric Neuropsychology may not be able to reverse the use or disclosure of my health information while the Authorization was in effect.

To be used if facility requests this authorization:

I understand that:

- 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 *"this facility's"* treatment of me, enrollment in the health plan, or eligibility for benefits.
- I may make a request in writing at any time to Wasatch Pediatric Neuropsychology 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).

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

If I have questions about disclosure of my health information, I can contact the Health Information Services / Medical Record Department.

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