ARUP LABORATORIES | Health & Wellness

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Authorization to Release Records from ARUP Family Health Clinic

DISCLOSURE OR RECEIPT OF PROTECTED HEALTH INFORMATION

Patient Name

Date of Birth **Phone #** **Medical Record #**

Patient Address

1. I authorize the following facility to **DISCLOSE** my patient information:

Name: ARUP Family Health Clinic **Address**: 500 Chipeta Way, Salt Lake City, UT 84108

2. I authorize the following person or organization to **RECEIVE** my patient information:

Name **Phone #** **Fax #**

Address

Name and contact information of the clinic where you want your records sent

3. Please disclose the following information pertaining to a diagnosis or event (check to indicate your selection):

Date(s) of Treatment (The treatment episode must have already occurred.)

Date(s) of treatment you want included on records

❑ History and physical ❑ Vaccinations ❑ Other: _____

❑ Consultation reports ❑ Lab reports _____

I give my permission for the following information to be released (please check and initial):

_____ ❑ HIV/AIDS-related information

_____ ❑ Alcohol/drug treatment information

_____ ❑ Sexually transmitted diseases

_____ ❑ Mental health (other than psychotherapy notes)

_____ ❑ Psychotherapy notes

(By checking this box, I am waiving any psychotherapist-patient privilege.)

What information you would like released and sent

4. Please describe the purpose of the disclosure. The purpose must be specific to the request and not for future unspecified treatment. _____

_____

_____

The reason you need this information

5. I understand that if the authorized recipient of this information is not a healthcare provider or health plan covered by federal privacy regulations, the information he/she/it receives will no longer be protected by these regulations, and the recipient may redisclose the information. However, the recipient may be prohibited from disclosing substance abuse records from a federally funded substance abuse treatment program.

Date and sign the back of this page.

6. I understand that ARUP Laboratories 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: ARUP Laboratories Privacy Officer MS241, 500 Chipeta Way, Salt Lake City, Utah 84108.

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires 90 days from the date I sign below.

Signature of Patient or Representative **Date**

Patient Name **Name of Personal Representative (if applicable)**

If signing as personal representative, describe authority to act for patient and submit documentation, such as power of attorney, showing such authority.

Witness (required if patient signs in the presence of ARUP Laboratories' staff)

(Notarization is not required if patient appears personally at ARUP Laboratories' facility and presents valid identification.)

Subscribed and sworn before me this _____ day of_____, 20_____.

_____
Notary Public

_____
Residence

_____
Date Commission Expires

(This signature page authorizes the release of testing records from ARUP Laboratories, Inc.)