Wasatch Behavioral Health

750 N. Freedom Blvd. Provo, UT 84601

Phone: (801) 373-4760 Fax: (801) 373-0639

Authorization to Request and/or Release Protected Health Information

Client Name: _____ Client ID: _____

Birth Date: _____ Email: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

The reason the information will be used or disclosed: _____

I authorize Wasatch Behavioral Health and the entity listed below to use and/or disclose my medical, mental health, and /or substance treatment records:

Person and Agency: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

I authorize the following for use and/or disclosure:

☐ Eval/Assmt ☐ Medication ☐ Discharge ☐ TX/Progress Notes

☐ Diagnosis ☐ TX/Care Plan ☐ Physician Notes ☐ Psychological Testing

☐ History/Physical ☐ Attendance ☐ Cooperation with Tx ☐ Drug Testing/UA Results

☐ Legal Involvement ☐ Presence at residential tx and access for visitation

☐ Other _____

Records including information related to a Substance Use Disorder ☐ False ■ True

Date Range of Information to be Release (if applicable): _____

By signing this form, I understand the following:

- I may revoke this authorization at any time, except to the extent that action has already been taken. To revoke this authorization, I must notify the Records Department in writing using the contact information above. Authorizations related to substance abuse records may be revoked verbally or in writing.
- There is the potential for re-disclosure of my mental health records by the receiver, and this re-disclosure may no longer be protected by federal or state law. Because of additional federal privacy rules (42 CFR Part 2), Substance abuse treatment records are prohibited from being re-disclosed without my written consent, unless permitted by federal or state law.
- I can request a copy of my record and/or inspect my record with my therapist. A supervisor will review and approve this request. I will receive an answer to my request within 30 days. My request may be denied if the supervisor of my case believes that access to my information could be harmful to me. If my request is denied I will be informed in writing.
- If I request a copy of my record for myself, I will be charged a fee of $5.00 at the time I submit my request. I will be charged an additional $0.25 per page to be paid at the time I pick up my records. (NOTE - records must be picked up within 30 days after notification that they are ready.)
- Signing this form is voluntary. It is not required to assure treatment with Wasatch Behavioral Health. The parent/guardian and the minor must both sign to release substance abuse treatment records of a minor.

Expiration Date (if left blank, expires one year from date signed: _____

Client Signature: _____ Date: _____

If Minor, Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Relationship to Client: _____