WASATCH MENTAL HEALTH
AUTHORIZATION

☐ **To request and/or disclose information to person/entity** ☐ **To request copies of records for myself**

SECTION I. Client Information

Client's Name: _____ WMH ID #: _____
Client's Former Names: _____
Date of Birth: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone #: _____ Email Address: _____
The reason the information will be used or disclosed: _____
_____

SECTION II. Complete this section if you are requesting copies of records be sent to another agency or you are requesting copies of records for your child or someone you have guardianship over (youth or adult)

I authorize Wasatch Mental Health and the person or entity listed below to use and/or disclose medical, mental health, and /or substance abuse treatment records:
Name(s) Person/Entity: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone #: _____ Fax # or Email: _____

SECTION III. Wasatch Mental Health Contact Information

Program Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone #: _____ Fax # or Email: _____

SECTION IV. I am authorizing the following information for use and/or disclosure:

☐ Eval/Assmt ☐ Medication ☐ Discharge ☐ Tx/Progress Notes ☐ Diagnosis ☐ Tx/Care Plan
☐ Physician Notes ☐ Psychological Testing ☐ History/Physical ☐ Other Information (explain)___
_____
Date range begin date: _____ Date range end date (optional): _____

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 **(750 N. 200 W, Provo, UT, 84601, fax to 801-373-0643).** 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. (Records must be picked up within 30 days after notification that they are ready).
- If this disclosure is set to expire based on an event, it is my responsibility to notify Wasatch Mental Health, in writing, when this event occurs.
- Signing this form is voluntary. It is not required to assure treatment with Wasatch Mental 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 on year from today's date unless revoked) _____
Expiration Event: _____

_____ _____
Client Signature Date

_____ _____
If Minor, Authorized Representative Signature Date

_____ _____
Printed Name of Authorized Representative Relationship

_____ _____
Witness Signature Date