Patient Authorization *for*

Use and Disclosure of Protected Health Information

Utah Neurological Clinic
1055 N 300 W Ste 400 • Provo, Utah 84604
Phone: 801-357-7404 • Fax: 801-357-7587

Patient Name: ______________________________ **Date:** ______________
Address: ______________________________ **Phone:** ______________
SSN: ______________________ **Date of Birth:** ______________________

**(Providing your SSN is voluntary, but not necessary to accurately identify your medical records. Failure to provide this information may delay the processing of your request.)*

I authorize the Utah Neurological Clinic TO RELEASE my patient information to:
Name: ______________________ Relationship to Patient: ______________
Address: ______________________ Phone # ______________ Fax # ______________

Scope of Use and/or Disclosure

Specific type of information to be disclosed by Utah Neurological Clinic:
☐ Treatment/progress notes ☐ Labs/radiology ☐ Hospital Notes ☐ Billing Summaries ☐ Rx/medications
☐ Other ______________________

Purpose of the Use and/or Disclosure

☐ At the request of the Patient ☐ Treatment ☐ Other (specify) ______________________

Expiration

I may revoke this consent at any time in writing. This **authorization expires 365 days** following the date signed, or on specified date, event, or condition listed: ______________________.

I hereby authorize the use and disclosure of my protected health information as described above and acknowledge the following:

- I understand that Utah Neurological Clinic will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law. I may inspect or copy any information used or disclosed under this authorization.
- I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information.
- I understand that if I have any questions about this authorization I may contact the practice's Privacy Official at (801) 357-7404, who will provide me with more information about this authorization or about Utah Neurological Clinic privacy practices.

I certify that I have read, signed and received a copy of this authorization.

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Parent, Guardian, or Personal Representative's Signature / Relationship to patient Date

______________________________ ______________
Witness Date

If signed by a Personal Representative, describe Personal Representative's authority to act for patient and include documentation showing such authority: ______________________________

(No Notary is required if the patient appears personally to the office to the Utah Neurological Clinic and presents proper identification)

SUBSCRIBED AND SWORN before me this __________ day of ______________________, 20____

____
Notary Public

Residing in ______________________

My Commission expires: ______________________

I hereby authorize the use and disclosure of my protected health information as described above and acknowledge the following:

- I understand that I am not required to sign this authorization and that I have the right to refuse to sign this authorization.
- I understand that Utah Neurological Clinic will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law. I may inspect or copy any information used or disclosed under this authorization.
- 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 receives will no longer be protected by these regulations, and the recipient may re-disclose the information.
- I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to **Utah Neurological Clinic.** However the revocation is not effective to the extent that action has been taken in reliance on this authorization.
- I understand that If I have any questions about this authorization, I may contact the practices Privacy Official at (801) 357-7404, who will provide me with more information about this authorization ,or about Utah Neurological Clinic privacy practices.

I certify that I have read, signed and received a copy of this authorization.

____   ______/ ______/ ______

Signature of Patient or Representative   Date

If signing as Personal Representative, describe authority to act for patient and submit documentation showing

such authority:____________________________________

____   ______/ ______/ ______

Signature of Authorized Employee   Date

(No Notary is required if the patient appears personally to the office of the Utah Neurological Clinic and presents proper identification.)

SUBSCRIBED AND SWORN before me this ______day of ____________,20_____.

____

Notary Public

Residing in _________________________

My Commission expires: ________________

DATE INFORMATION WAS RELEASED:______/ ______/ ______