Comprehensive Psych
COMPREHENSIVE PSYCHOLOGICAL SERVICES

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Salt Lake City, Utah 84106
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For Office Use Only ☐ Leave on File ☐ Medical Records Request

Authorization to Use and Disclose Protected Health Information

PATIENT INFORMATION

Patient Name:______________________________ Date of Birth: ____________________

Current Address: ____

City: ______________________ State: __________ Zip: ______________

Phone Number: (__________)______________________________________

OTHER PARTY (Party Who We Will Obtain or Release Information)

Facility/Provider/Other: ______________________ Relationship to patient: ____________________

Address: ____

City: ______________________ State: __________ Zip: ______________

Phone Number: (__________)________________ Fax Number: (________)____________________

I authorize Comprehensive Psychological Services (CPS) to communicate with the **OTHER PARTY** in the following way(s) (check all that apply):

☐ Exchange Records and Verbal Communication with ☐ Release Records To ☐ Obtain Records From

Would you like to specify that we only release certain parts of your medical record or a specific range of dates of service?
(For example: "I would like you to release my ADD evaluation only," or, "I would like you to release my record for the year 2015 only.")
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____
*Unless otherwise noted above, this authorization will release your entire medical record or what your provider decides to release.

Would you like to place an expiration date on this release? ______________________________________
*Unless otherwise noted above, this authorization will not expire.

I understand that I may be charged for this information and I agree to be financially responsible for the charge.

Print Name of Patient: ____________________**Date of Birth**:______________________ **Date**: ____________

Signature of Patient or Legal Representative or Custodial Parent? Guardian: ______________________________

Print Name of Legal Representative (if applicable): ______________________________________

Relationship to Patient (if applicable): ______________________________________

I understand the following:

If applicable, I understand that based on dates, providers and information I have designated above; the disclosure Comprehensive Psychological Services makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

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. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that Comprehensive Psychological Services 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.

I understand that I may revoke this authorization in writing at any time by mailing a written revocation of authorization to Comprehensive Psychological Services. I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization.