



**HIPAA Disclosure Authorization Form
Release of Private Health Information**

I, _____, hereby authorize Central Utah Clinic, P.C. (**Central Utah**) to disclose protected health information about me as described below.

1. The following person or class of persons, or facility may receive the disclosure of protected health information.

Name: _____

Relationship: _____

2. Specific information to be disclosed is: *(if blank the complete record will be disclosed)*
3. I understand that if the person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
4. I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to MEDICAL RECORDS MANAGER. However, if I do revoke this authorization my revocation will not affect any prior actions taken in reliance on my authorization.
5. This authorization will expire on ____/____/____ (MM/DD/YR); or upon the following event:

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

Signature of Patient or Patient's Representative

Patient's Date of Birth

DATE

Relationship of Representative to Patient

Reps. Date of Birth or SS #