



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.

City State Zip

Phone Fax

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 #