



## HIPAA Disclosure Authorization Form

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

1. The following person or class of persons, or facility is authorized to disclose protected health information to **Central Utah Clinic, 1055 N. 500 W. Provo, Utah 84604:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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 #