AUTHORIZATION to disclose Protected Health Information (PHI)

Complete ALL fields.

Client name: (Please print)		DOB:	VBH ID #:
Phone #:			SSN:
Client Address:			
Email:	City:	State:	Zip

Please indicate the purpose of the disclosure:
☐Coordination of care ☐Legal/Court ☐Personal/Family ☐Other____
Please indicate the information to be disclosed:
☐Progress Notes ☐Assessment/Diagnosis ☐Medication Notes ☐Care Plan ☐Discharge Summary ☐Billing
☐Drug Testing ☐Substance Use records ☐Billing ☐Other____
Date range of information to be disclosed: ____
Authorization expiration: (please check one) If no option is marked, this authorization will expire 1 year from date signed.
☐1-time disclosure ☐6 months ☐Other____

I authorize Valley Behavioral Health to disclose my information listed above to the following persons:

Name: (Please print) (**Contact name must be filled in**)			Agency:	
Phone #:			Fax #:	
Address:				Email:
	City:	State:	Zip:	

I understand that my substance use disorder (SUD) records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand signing this form is voluntary and not required to receive services with VBH. I understand I may revoke this authorization at any time by completing and submitting VBH's Letter of Revocation form. Revocation will not include any information already shared in reliance upon this authorization. If I am court-ordered and end this authorization, I understand this will affect my standing with the courts and the courts will be notified of my revocation. I understand that any disclosure of this information has the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. VBH *does not re-disclose* PHI received from 3rd party providers, entities and/or agencies, except where required by law, including to the client themselves.

I understand I can request a copy of my record. My provider(s) will review my request and the request can be denied if the records are found to be detrimental to myself, my treatment, or others. I understand I can make an appointment with my provider(s) to discuss this decision and review my records by making an appointment. The request can take 30 days to complete and charges may apply.

If this is for a minor with any possible history of and/or currently in SUD treatment, both minor and parent/legal guardian must sign the form. A step-parent cannot sign this form without notarized written consent from the legal/custodial parent of the minor client. "Foster Parent" is not the legal guardian and cannot sign this form.

Signature of Client or Representative:		Date:
Printed name of Representative:		
Representative's Authority: ☐Parent ☐Medical Power of Attorney ☐Other**, Explain______________________ **Please attach documentation to support legal representation.		
Signature of VBH staff member:	Printed name of staff member:	Date:

VBH Medical Records Contact Information: 4460 S Highland Drive, Suite 320, Salt Lake City, UT, 84124; P: 801-273-6425, F: 385-388-8670
Copy given to client: ☐Yes ☐Declined Verified by: ☐License ☐Other ID ☐Known to VBH MRF01 08-19