



State of Utah

GARY R. HERBERT  
Governor

SPENCER J. COX  
Lieutenant Governor

Department of Human Services

ANN SILVERBERG WILLIAMSON  
Executive Director

Division of Child and Family Services

BRENT PLATT  
Director

AUTHORIZATION TO RELEASE INFORMATION TO THE  
DIVISION OF CHILD AND FAMILY SERVICES (DCFS)

1. I authorize the health care provider(s) listed below to disclose the protected health information of:

Name of Patient/Client (print) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone Number ( ) \_\_\_\_\_ Soc. Sec. # (optional) \_\_\_\_\_

2. The PURPOSE of this release of information is for: Complying with DCFS Statutory Guidelines, which includes providing protection and services to children and families at risk. This may also include reporting to the Court.

Information requested from: (Physician/Facility Name and Location)	My entire record, including medical, psychological, psychiatric information, except for: (specify)	Dates of service between: ____/____/____ And ____/____/____
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4. I authorize disclosure of substance abuse information.  Yes  No (If Yes, please complete this section.)

I authorize the following provider(s) to disclose complete substance abuse information: \_\_\_\_\_ (Provider Name)

For dates of service between \_\_\_\_\_ and \_\_\_\_\_

I understand, by initialing this box, I am allowing the disclosure to DCFS of substance abuse information protected by Federal confidentiality rules (42 CFR part 2). Records given to DCFS cannot be used to investigate or prosecute me for a criminal offense unless ordered by a court.

Patient/Client Initials:  Parent Initials:

(If the records being requested are a minor's, both the minor and the parent must sign and initial this form.)

5. Provide these records to the following DCFS Office Location:

Contact Person \_\_\_\_\_ Position \_\_\_\_\_  
DCFS Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

6. This authorization will remain in effect for one year from signature date, unless otherwise specified below, or until I revoke it. (see 7B below)

6 months from date signed  For one-time disclosure only  Other event or time:  
(Please specify) \_\_\_\_\_

7. I understand:

- A. I may decide not to sign this authorization. The provider(s) listed above will not deny me services for that reason.
- B. If I do sign this authorization, I may revoke it at any time, except as to records that have already been disclosed. To revoke this authorization, I need to send a revocation in writing to the provider(s) above, except I can revoke the disclosure of substance abuse information by telling my provider(s).
- C. DCFS may redisclose my records if permitted by law. Federal confidentiality rules (42 CFR part 2) restrict the redisclosure of my substance abuse information without my written consent, except for the limited instances when these confidentiality rules permit redisclosure or when a court orders redisclosure.
- D. I understand that I can request a copy of the information disclosed to DCFS from the provider(s) listed above. (Sections 3 and 4)

_____ Signature of Patient/Client	_____ Date
_____ Signature of Parent/Personal Representative (if applicable)	_____ Relationship/Description of Authority
_____ Signature of DCFS Worker verifying identity of Signatory	_____ Date

## Authorization to Use and Disclose Protected Health Information

<b>Authorization to release the protected health information of:</b>			
Patient Name:		MRN:	EMPI#
Current Address		City	State Zip
Social Security Number - - -		Phone Number ( )	Date of Birth / /
<b>This authorization is to release the protected health information to:</b>			
Name		Phone Number ( )	
Address		City	State Zip
Release by: In Person <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Fax Number : Secure Email <input type="checkbox"/> Secure Email Address:			
<b>This authorization is to release the protected health information from:</b>			
Facility Name/Provider		Phone Number ( )	
Address		City	State Zip
Release by: In Person <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Fax Number : Secure Email <input type="checkbox"/> Secure Email Address:			
<b>The purpose of this disclosure is:</b>			
<b>Dates of service requested:</b>			
<b>Release the following information:</b>			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology report(s)	<input type="checkbox"/> Itemized Billing Statement	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology report(s)	<input type="checkbox"/> Psychiatric Admitting Evaluation	
<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Lab report(s)	<input type="checkbox"/> Psychiatric Discharge Summary	
<input type="checkbox"/> Operative report(s)	<input type="checkbox"/> Cardiology report(s)	<input type="checkbox"/> Psychiatric testing	
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Treatment Plan(s)	<input type="checkbox"/> Other records as specified: _____	
<input type="checkbox"/> Emergency record(s)	<input type="checkbox"/> Alcohol/Drug Treatment record(s)* _____		
<b>This Authorization will remain in effect:</b>			
<input type="checkbox"/> From the date of this Authorization until: _____			
<input type="checkbox"/> Until the following event occurs: _____			
Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.			

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that the Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to "this facility" to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR § 164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Management/Medical Record Department. If I revoke this Authorization, Intermountain healthcare may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.

**To be used if facility requests this authorization:**

I understand that:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility" treatment of me, enrollment in the health plan, or eligibility for benefits.
- Chemical dependency treatment records are protected by Federal Rule 42 CFR, part 2. Both a minor's and a parent guardian's signature must be obtained prior to disclosing the minor's chemical dependency treatment records.

If I have questions about disclosure of my health information, I can contact the Health Information Management Medical Record Department

Signature of Patient or Legal Representative:	Date
If Signed by Legal Representative, Authority:	Signature of Witness (optional)

