UTAH AUTHORIZATION TO DISCLOSE HEALTH RECORDS TO A LAW ENFORCEMENT AGENCY

(For Law Enforcement Use Only. Deliver in person, or if mailed/faxed, with cover letter on agency letterhead. Complete all sections.)

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

Name of Patient *(print)* _____ Date of Birth_____

Phone Number_(____)_____ Soc. Sec.# *(optional)*_____

Address_____

City_____ State_____ Zip _____

2. Record(s) Requested from:	**Complete record(s) consisting of:**	**Between the dates of:**
A. (i) *(Physician/Facility Name and Location)*	**A. (ii)**(*Check all that apply)* ❑ Inpatient record ❑ Outpatient record ❑ Emergency record ❑ Ambulance/transport record ❑ Other_____	**A. (iii)** _____ to_____
B. (i) *(Physician/Facility Name and Location)*	**B. (ii)**(*Check all that apply)* ❑ Inpatient record ❑ Outpatient record ❑ Emergency record ❑ Ambulance/transport record ❑ Other_____	**B. (iii)** _____ to_____

C. I authorize my complete **substance abuse treatment records** to be disclosed from the following provider(s):
(i)_____from the dates of: (ii)_____to _____.
(Physician/Facility Name and Location)

I understand, by initiating this box, that I am allowing the disclosure to law enforcement of my substance abuse treatment records protected by Federal confidentiality rules (42 CFR part 2), and which are prohibited from redisclosure without my written consent (or otherwise permitted by these rules). Records given to law enforcement by this disclosure cannot be used to investigate or prosecute me for a criminal offense unless ordered by a court.

Patient initials: ☐

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

3. Provide these records to the following Law Enforcement Agency: (*Agency name, address, phone)***:**

4. Unless revoked *(see 5. B below)* **this authorization will remain in effect until:** *(check one)*

❑ 1 year from date signed ❑ For one time disclosure only ❑ Other event or time:
*(Please specify)*_____

5. I understand:

A. I may decide not to sign this authorization. The provider(s) listed above will not deny me treatment solely for that reason.

B. If I do sign this authorization, I may revoke it at any time, unless the provider(s) have relied on my authorization and have already disclosed the records. **To revoke this authorization, I need to send a revocation in writing to the provider(s) above**.

C. The law enforcement agency that receives the records may redisclose them if permitted by law. Only records protected by Federal confidentiality rules 42 CFR part 2 (specified in Section 2. C above), are restricted from redisclosure unless I give written consent, unless redisclosure is permitted by these confidentiality rules, or if ordered by a court.

D. If I want to know what is in these records, I can contact the provider(s) listed above for access to these records.

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Parent/Guardian [if applicable] *Relationship to Patient*

6. ***I hereby verify the identity of the person(s) signing above and that these records will be used for law enforcement purposes only.***

_____ _____ _____
Signature of Law Enforcement Officer *Badge or Attorney Bar #* *Agency*

_____ _____ _____
Print Officer's Name *Agency Case Number* *Dispatcher's Phone (for verification)*