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.)

	Patient (print) Date of Birth umber_() Soc. Sec.# (optional)		th records of: Birth
Phone Number_(Soc. Sec.# (optional)	
Address			
City	sted from:	State	Zip Zip Between the dates of:
		A. (ii)(Check all that apply)	A. (iii)
A. (I) (Physician/Fa	cility Name and Location)	☐ Inpatient record	7. (III)
		□ Outpatient record	to
		□ Emergency record	
		Ambulance/transport record	
		□ Other	
B. (i) (Physician/Fa	acility Name and Location)	B. (ii)(Check all that apply)	B. (iii)
		□ Inpatient record	to
		□ Outpatient record	
		Emergency recordAmbulance/transport record	
		□ Other	
C. I authorize my	complete substance abu	se treatment records to be disclosed	from the following provider(s):
(i)	·		es of: (ii)to
(Physician/Facility	Name and Location)		
		ım allowing the disclosure to law enforc	
		nfidentiality rules (42 CFR part 2), and	
		ermitted by these rules). Records give	
disclosure canno	of be used to investigate of	r prosecute me for a criminal offense ur	Patient initials:
(If the records re	oquested are a minor's hot	th the minor and the parent must sign a	
(II the records re	quested are a minor s, bot	in the minor and the parent must sign a	ind initial tins form.)
Provide these red	cords to the following La	aw Enforcement Agency: (Agency nar	me, address, phone):
Provide these red	cords to the following La	aw Enforcement Agency: (Agency nar	me, address, phone):
Unless revoked (see 5. B below) this author	orization will remain in effect until: (check one)
Unless revoked (see 5. B below) this author	orization will remain in effect until: (a	check one) Other event or time:
Unless revoked (see 5. B below) this author	orization will remain in effect until: (a	check one)
Unless revoked (1 year fro I understand: A. I may decide n	See 5. B below) this authom date signed	orization will remain in effect until: (a) For one time disclosure only The provider(s) listed above will not deny me	check one) Other event or time: (Please specify) e treatment solely for that reason.
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