



UTAH COUNTY HEALTH DEPARTMENT
YOU WILL RECEIVE A RESPONSE IN 2-3 BUSINESS DAYS
FROM THE TIME WE RECEIVE YOUR FAX

PATIENT NAME: Last First MI Maiden or Other Name

DATE OF BIRTH: - -

I authorize the release of information held by the Utah County Health Department (UCHD) to:

NAME:

ADDRESS: CITY: STATE: ZIP:

PHONE: FAX: EMAIL:

I authorize the release of information held by to the Utah County Health Department (UCHD).

Please send material to:
Utah County Health Department
151 S University Ave #1610
Provo, UT 84601
Phone: 801-851-7025 Fax: 801-851-7055 Email: shirleyo@utah.gov

INFORMATION TO BE RELEASED:

- History and physical exam
Nursing Notes
X-ray reports
Immunizations
Cholesterol
STD
HIV related information
Incident/Short encounters
Other:
DATES

PURPOSE OF DISCLOSURE:

- Changing Physicians
School
Legal
Consultation/second opinion
Insurance
Continuing Care
Workers Compensation
Personal
Other (please specify):

- 1. I understand that this authorization will expire 90 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing...
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure...
4. By authorizing this release of information, I understand that my health care and payment for my health care will not be affected.
5. I understand that I may have a copy of the information described on this form and a copy of this form after I have signed it.
6. I have been informed that Utah County Health Department will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

PLEASE PRINT NAME DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: BY:

IDENTIFICATION PRESENTED: