AUTHORIZATION TO USE AN DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE RELEASE MY RECORDS

❑ **I would like my records sent to:** *Dr. Gary Behrmann, Pediatrics* *Phone#:(801)465-4877, Fax#:(801)465-4879*
1172 East 100 North, Suite 2, Payson, UT 84651 gbmd4877@yahoo.com

From: Name:____________________ Phone#:__________ Fax#:__________
Address:____________________ City:__________ State_____ Zip _____

OR

❑ **I would like my records sent from:** *Dr. Gary Behrmann, Pediatrics* *Phone#:(801)465-4877, Fax#:(801)465-4879*
1172 East 100 North, Suite 2, Payson, UT 84651 gbmd4877@yahoo.com

To: Name:____________________ Phone#:__________ Fax#:__________
Address:____________________ City:__________ State_____ Zip _____

OR

❑ **I authorize my protected health information may be released to:** ____________________
who is ____________________ to the patient.

Full Names of Patient's Father & Mother:____________________

Home Phone Number: ____________________ **Alternate Phone Number:**____________________

Authorization to release the health information of:

Patient's Full Name Social Security Number	Date of Birth	Vaccines	Office Records	Hospital Records	Labs	Other

The purpose of this disclosure is: ❑ Patient Request ❑ Treatment ❑ Payment Purposes ❑ Other:__________

This Authorization will remain in effect:

❑ From this date of this authorization until:____________________.

❑ 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 Dr. Gary Behrmann, Pediatrics discloses my health information by my request, it cannot guarantee that recipient will not re-disclose 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.
- My records are protected and cannot be disclosed without my permission. *Alcohol/drug treatment records are protected by Federal Rule 42 CFR, part 2.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to Dr. Gary Behrmann, Pediatrics.

To be used if Dr. Gary Behrmann, Pediatrics 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 treatment.
- I can make a request in writing at any time to Dr. Gary Behrmann, Pediatrics to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524
- If I have questions about disclosure of my health information, I can contact Dr. Gary Behrmann, Pediatrics Privacy Officer, Cassi Bradford, at (801)465-4877 or in writing at 1172 E 100 N, #2, Payson, UT 84651.

Signature of Patient or Legal Representative	Date
Relationship to Patient	Signature of Witness (Optional)

FOR OFFICE USE ONLY

Verify ID: Type	Employee Initials:	❑ Mailed / /	❑ Faxed / /	❑ Picked-up / /