HighlandSprings™
A VALLEY SPECIALTY CLINIC

Authorization

To Use and Disclose Protected Health Information (PHI)

ALL fields are required to be completed.

HSSC # _____

Client Name: _____ DOB: _____

Address: _____ ☐ HOMELESS Home: _____

City: _____ State: _____ Zip: _____ Cell: _____

Highland Springs Speciality Clinics (HSSC) follows federal and state confidentiality regulations prohibiting release of information about you without your permission or as otherwise permitted or required by law. See Highland Springs Speciality Clinics's Notice of Privacy Practices. Substance Abuse (SUD) treatment records have additional privacy protections (42 CFR Part 2). I understand that use and disclosure means sharing of my medical records including verbal, written and electronic communications. I give permission for HSSC and the person/organization listed below to share my medical, mental health, behavioral health and/or substance abuse treatment records. HSSC *does not re-disclose* PHI received from 3rd party providers, entities and/or agencies, except where required by law.

NAME OR OTHER SPECIFIC IDENTIFCATION OF THE AGENCY OR PERSON AUTHORIZED TO RECEIVE/ MAKE THE REQUESTED USE OR DISCLOSURE:

Agency/Name: _____ Attn: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Email: _____

PURPOSE: Please mark the reason the information is to be used or disclosed: *2-Way Verbal Communication is authorized upon signing this release form.*

☐ Coord. of Care ☐ Legal/Court ☐ Court Order Tx. ☐ Probation ☐ *Personal/Family ☐ School ☐ Benefits Eligibility/Coord.

☐ Short/Long Term Disability ☐ Billing/Payments ☐ Other: _____

EXPIRATION: ☐ 1 time disclosure ☐ 6 months ☐ End of HSSC Treatment *If no option is marked this form will expire 1 year from date signed.*

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

☐ All Records ☐ Progress Notes ☐ Assessment/Diagnosis ☐ Medication/Nurse Notes ☐ Care Plan ☐ Group Notes ☐ Discharge

☐ Drug Testing ☒ A&D (required for A&D info) ☐ Billing ☐ Other: _____

NOTICE TO CLIENT: Signing this form is voluntary and not required to receive services with HSSC. I understand I may revoke this authorization at any time. To revoke this authorization, I will complete and submit HSSC's written Letter of Revocation form. Verbal revocation can be honored for drug and/or alcohol treatment records only. If I am court ordered and end this authorization, I understand this will affect my standing with the courts and the courts will be notified of my revocation. Revocation will not include any information already shared in reliance upon this authorization. I understand that any disclosure of this information has the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse (SUD) Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. If this is for a minor in a Substance Abuse Treatment (SUD) program, both minor and parent/ guardian must sign the form. *A step-parent cannot sign this form without notarized written consent from the legal/custodial parent of the minor client. "Foster Parent" is not the legal guardian and cannot sign this form*. The request can take 30+ days to complete and charges will apply.

*ACCESS TO MY RECORD: I understand I can request a copy of my record. My provider(s) will review my request and the request can be denied if the records are found to be detrimental to myself, my treatment or others. I understand I can make an appointment with my provider(s) to discuss this decision and review my records by making an appointment. The request can take 30+ days to complete and charges will apply.

By signing this form I have read and accept all parts of this form.

Client Signature ▶ _____ Date ▶ _____

Representative Signature ▶ _____ Date ▶ _____

Representative Name (print) ▶ _____ Relationship ▶ _____

Witness Signature ▶ _____ Date ▶ _____

HSSC MEDICAL RECORDS CONTACT INFORMATION

Address: 4460 SOUTH HIGHLAND DRIVE, SUITE 320, SALT LAKE CITY, UTAH 84124 Phone# 801-273-6425 Fax: 801-424-4043

Copy Given to Client: ☐ Yes ☐ Declined Verified By: ☐ Other ☐ License ☐ Other ID ☐ Known to HSSC