UFI
UTAH FAMILY INSTITUTE, L.L.C.
1471 North 1200 West
Orem, Utah 84057
Telephone: (801) 802-9464
Fax: (801) 802-7861

Patients Authorization

Authorization for Use or Disclosure of Protected Health Information

I authorize my therapist and/or administrative and clinical staff to (check all that apply):

__ use the following protected health information, and/or

__disclose the following protected health information to the following individual/s or entities:

_____Fax#:_____

_____Phone#:_____

_____

Describe information to be disclosed:

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

_____

__ Patient does not wish to disclose purpose: _____

This authorization shall be in force and effect until the following date: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Utah Family Institute
"Privacy Contact"
1471 North 1200 West
Orem, Utah 84057

I understand that a revocation is not effective to the extent that my therapist has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. (Unless state or federal law disallows this stipulation, then the remaining authorization shall be affective with only the disallowable portion being excluded if applicable).

My therapist will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Print Name of Patient or Personal Representative | Description of Personal Representative's Authority

[Provide a copy of this form to the patient]