Updated 10/6/2021

WEBER-MORGAN HEALTH DEPARTMENT
AUTHORIZATION TO USE, DISCLOSE, OR REQUEST HEALTH INFORMATION

Cost: $2 fee for state records copy (printout)
$5 fee for immunization record (card)

I, _____, hereby authorize the_____ *(Client or Personal Representative)* to use, disclose, and/or request the following specific private health information to and/or from the entity listed below for the purpose as identified.

Client Name _____
Date of Birth_____

Recipient information: Name _____

Address _____

City _____ State ___ Zip_____

Phone_____ Fax_____

Specific purpose(s):
_____
_____

Specific information to be used, disclosed and/or requested:
_____
_____

I understand that this authorization will expire on the following date, event or condition:
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for uses, disclosures and/or requests for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time, by signing the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my WMHD health information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my WMHD record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.
I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g.. insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____/_____ _____
(Signature of Client) *(Date)* *(Witness-If Required)*

_____/_____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

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*NOTE: This Authorization was revoked on*_____. _____
(Date) *(Signature of Staff)*

Request completed by_____ Date _____

REVOCATION SECTION

I do hereby request that this authorization to Weber-Morgan Health Department to disclose or use health information of

_____ signed by_____
(Name of Client) *(Enter Name of Person Who Signed Authorization)*

on _____ be rescinded, effective _____.
(Enter Date of Signature) *(Date)*

I understand that any action taken by WMHD or related business associates on this authorization prior to the rescinded date are legal and binding.

_____/_____ _____/_____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____/_____ _____
(Signature of Personal Representative) *(Date)* *Personal Representative Relationship/Authority)*

Please submit this form to the Weber-Morgan Health Department in person, by mail, fax, or email.

477 23rd Street, Ogden, Utah 84401 - 1st floor Clinical Nursing Services

Fax: 801-399-7233

Email: clinicstaff@co.weber.ut.us

Acceptable forms of payment:
Cash
Check payable to: Weber-Morgan Health Department
Credit or Debit card by phone or in-person.