



AUTHORIZATION TO USE AND DISCLOSE RECORDS

Patient Information	
Name:	Date of Birth:
Address:	Phone Number:
City, State, ZIP:	

Provider Information	
Name:	Phone Number:
Address:	City, State, ZIP:

I authorize CSHCN to RELEASE records to above provider. Patient/Legal Rep. Initials: _____

I authorize CSHCN to REQUEST records from above provider. Patient/Legal Rep. Initials: _____
 (****Please send all information to address checked below****)

<input type="checkbox"/> CSHCN Integrated Services Program 950 25 th St. Ste.C Ogden, UT 84401 Fax: 801-393-3349 Ph: 801-395-5907/801-395-5908	<input type="checkbox"/> CSHCN Integrated Services Program 44 North Mario Capecchi Dr. PO Box 144610 Salt Lake City, UT 84114-4610 Fax: 801-584-8242 Ph: 801-584-8246	<input type="checkbox"/> CSHCN Medical Records PO Box 144610 Salt Lake City, UT 84114-4610 Fax: 801-584-8590 Ph: 801-584-8537
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Release the following information:

<input type="checkbox"/> Admit/Discharge Summary	<input type="checkbox"/> IEP/IFSP	<input type="checkbox"/> School Records
<input type="checkbox"/> Birth/Newborn Records	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Social Services
<input type="checkbox"/> Dental Records	<input type="checkbox"/> IQ/Psychological Testing	<input type="checkbox"/> Speech/Language Assessments
<input type="checkbox"/> Developmental Assessments	<input type="checkbox"/> Lab or Radiology Reports	<input type="checkbox"/> Surgical Reports
<input type="checkbox"/> Feeding/Nutrition	<input type="checkbox"/> Medical records	<input type="checkbox"/> Vision Screening/Testing
<input type="checkbox"/> Growth Charts	<input type="checkbox"/> Newborn Screening Tests	<input type="checkbox"/> Other Records as Specified: _____
<input type="checkbox"/> Hearing Screens/Tests	<input type="checkbox"/> OT/PT Reports	

Dates of Service Requested: _____

- By signing below, I understand that:
1. This consent remains effective for **1 year** from the date last signed.
 2. I may revoke this authorization at any time by giving written notice. Any actions already taken in reliance on this authorization will not be affected by my revocation.
 3. Treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on whether I sign this authorization. If an exception applies, the consequences to me will be explained.
 4. I understand once the information is disclosed, this facility cannot guarantee that the 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 laws governing the use and disclosure of my health information.
 5. I may make a request in writing at any time 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.

Print Name of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	If Signed by Legal Representative, Authority:

*For questions regarding the disclosure of information contained in this release, please contact specified Program above.