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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Salt Lake County Jail ♦ 3415 South 900 West ♦ Salt Lake City, UT 84119 ♦ 385-468-8604 ♦ FAX 385-468-8722

Information to be Used or Disclosed

The information covered by this authorization includes (list specific condition or dates):

_____

Persons Authorized to Disclose information

Information listed above will be used or disclosed by (party we are requesting info from)

Name of person or organization | Fax #

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Name of person or organization | Address of person or Organization | Contact # when records are ready

Purpose of Disclosure

["At the request of the individual" when individual initiates authorization and does not provide purpose]

Please send records or inquiries to: Privacy Officer, Phone: 385-468-8600 Fax 385-468-8722

Expiration Date of Authorization: This authorization is effective for six months unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization You may revoke or terminate this authorization by submitting a written revocation to the Salt Lake County Sheriff's Office; Corrections Bureau; 3415 South 900 West; SLC, UT 84119. You should contact the Privacy Officer to terminate this authorization. The Authorization may not be revoked if the Sheriff's Office has already taken action in reliance on your Authorization

Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. THIS IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS (including 45 CFR, Parts 160 7 164. Standards for Privacy of Individual Identifiable Health Information; and 42 CFR, Chapter 1 Part 2. Confidentiality for Alcohol and Drug Abuse Patient Records)

Your refusal to sign this authorization will not affect your ability to obtain treatment, payment or eligibility for health care benefits. I understand my records may include information pertaining to psychiatric issues, alcohol and/or drug abuse treatment and/or HIV status.

I understand that I will be responsible for copy costs of **.50 cents per page.** I authorize copy costs of up to $_____ to be deducted from my jail fund account. **The Sheriff's Office does <u>not</u> waive costs for HIPAA requests for prisoners**

Name of patient (Print or type) | SO #

Patient's DOB | Patient's SS #

Signature of Patient | Date

Witness | MIS #