HIM Department - Medical Records
4460 South Highland Drive, Suite 320
Salt Lake City, UT 84124
(P) 801-273-6425 (F) 801-424-4043

Please have the adult client or custodial parent/guardian of minor client (17 years and younger) **completely** fill out the authorization form. If the parents are separated, divorced or if the parents do not have custody, a copy of the court order signed by a judge showing custody of the minor is required and must accompany the request. If the minor (17 years and younger) is in a substance abuse treatment program, both minor client and the parent/guardian of the minor will need to sign the authorization form. **Foster Parents cannot request records. *Step-parents must have written and notarized authorization from the legal parent to sign this form and request records. Legal guardians must provide judge signed documents stating their guardianship.*

(*DCFS requests, please read the bottom portion of the email.)
The processing time to request records can take 30+ days to process the request for records. You will not be able to pick up the records the day you drop of the request. Medical Records does attempt to process the request as quickly as possible, however we cannot guarantee a specific date prior to the 30 days. If client is requesting their records for themselves, please put "SELF" in the second box. Only **1 recipient** per form. If you are requesting records to be sent to more than 1 individual or agency a separate authorization form will need to be completed for each recipient. A copy of the clients ID must accompany the request, a copy of the parent/guardian ID must accompany the request if the client is under 18 years of age.

Charges do apply.

If requesting records for any of the agencies listed below, the following information is required in the second box; name of the office/agency receiving the records, address, and phone number and fax number (if possible). If it's for court and you know the name of the judge hearing the case, please include that as well.

- Doctor, Hospital, Clinic
- Court, Attorney, Probation Officer
- School
- Insurance
- DCFS (*see below)
- Vocational Rehab, Social Security

Submitting the form; the completed form(s) can be returned by any of the following ways;

- Scan and email the form(s) back to my email address.
- Drop the forms off at any of the Valley Behavioral Health Clinics at the check-in desk, make sure you ask them to **fax** it to Medical Records.
- Mail or fax the form(s) over to the Medical Records information that is located on the bottom of the page, fax 801.424.4043
- Drop of the form at the Medical Records office located at 4460 South Highland Drive, Suite 320, Salt Lake City, UT 84124

*If the records are you are requesting are for a minor and he/she has seen by Valley Behavioral Health prior to being placed with DCFS the form must be signed by the minor's parents/guardian(s) not by DCFS or any state office (CPS) and a copy of the court order signed by the judge stating the date the minor was placed with DCFS is required. If the mother/father are not the legal guardian, a copy of the judge signed court order naming the guardian of the minor is required.

*If the records you are requesting are for the minor child for the time frame after he/she was placed with DCFS then the form can be signed by the DCFS case worker and a copy of the court order signed by the judge stating the date the minor was placed with DCFS is required. Foster Parents CANNOT sign authorization forms, they are not the legal guardians.

NOTE: **Any and all changes made to any Authorization Form must be initialed by the adult client or by the parent/guardian of the minor client to be valid. An Authorization Form with changes made that are not initialed will be returned unprocessed.**
Please note that Valley Behavioral Health does not to release records received from 3rd party providers (other providers outside of Valley Behavioral Health).

Authorization

To Use and Disclose Protected Health Information (PHI)

ALL fields are required to be completed.

VBH # _____

Client Name: _____ DOB: _____

Address: _____ ☐ HOMELESS Home# _____

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

Valley Behavioral Health (VBH) follows federal and state confidentiality regulations prohibiting release of information about you without your permission or as otherwise permitted or required by law. See Valley Behavioral Health'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 VBH and the person/organization listed below to share my medical, mental health, behavioral health and/or substance abuse treatment records. VBH *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 Comm. (Verbal Only) ☐ Coord. of Care ☐ Probation ☐ Legal/Court ☐ Court Ordered Tx. ☐ School ☐ *Personal/Family

☐ Benefits Eligibility/Coord. ☐ Other: _____

EXPIRATION: ☐ 1 time disclosure ☐ 6 months ☐ End of VBH Treatment - 1 year from date signed, unless revoked, if no option is marked.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

☐ All Records ☐ Progress Notes ☐ Evaluations ☐ Diagnosis ☐ Medication Notes ☐ Care Plan ☐ Group Notes ☐ Discharge

☐ Nurse Notes ☐ SUD (must be marked for SUD info) ☐ Drug Testing ☐ Other: _____

NOTICE TO CLIENT: Signing this form is voluntary and not required to receive services with VBH. I understand I may revoke this authorization at any time. To revoke this authorization, I will complete and submit VBH'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 ▶

VBH MEDICAL RECORDS CONTACT INFORMATION

Program: MEDICAL RECORDS Attn: _____

Address: 4460 SOUTH HIGHLAND DRIVE, SUITE 320 Phone# 801-273-6425

City: SALT LAKE CITY State: UTAH Zip: 84124 Fax# 801-424-4043

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