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 the 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 stating custody of the minor(s) is required and must accompany the request. If the minor (17 years and younger) has been or is currently 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 sign this form.

(*DCFS requests, please read the bottom red portion.)

The processing time to request records take approximately 30 days to complete. You will not be able to up the records the day you drop of the request, due to the processing time. 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 you are requesting your records for yourself, 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.

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
- DCFS (*see below)
- Vocational Rehab, Social Security

Submitting the request.

The completed form(s) can be submitted by any of the following ways;

1. Scan and save as a pdf file and email the form(s) back to a Medical Records email address, wendyg@valleycares.com.
2. Drop the form(s) off at any of the Valley Behavioral Health Clinics at the check-in desk.
3. Drop of the form at the Medical Records office located at 4460 South Highland Drive, Suite 320, Salt Lake City, UT 84124
4. Mail or fax the form(s) to the Medical Records information that is located on the bottom of the page, fax 801.424.4043

*If you are requesting records for a minor (17 years and younger) and he/she has been 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). A copy of the judge signed court order stating the placement date with DCFS is also required. If the mother/father are not the legal guardian(s), a copy of the judge signed court order naming the guardian of the minor is required.

*If you are requesting records for a minor (17 years and younger) 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 judge signed court order stating the placement date with DCFS is also 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 and Highland Springs Specialty Clinics does not to release records received from 3rd party providers.

Authorization

To Use and Disclose Protected Health Information

ALL fields must be completed in order to process the request.

VBH # _____

Client Name: _____ DOB: _____

Address: _____ ☐ HOMELESS Home# _____

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

Valley Behavioral Health 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 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 Valley Behavioral Health and the person/organization listed below to share my medical, mental health, behavioral health and/or substance abuse treatment records.

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 If nothing marked - one year from date signed unless revoked

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

☐ All Records ☐ Progress Notes ☐ Evaluations ☐ Diagnosis ☐ Medication Notes ☐ Care Plan ☐ Group Notes ☐ Drug Test

☐ Discharge ☐ Other: _____

NOTICE TO CLIENT: Signing this form is voluntary and not required to receive services with Valley Behavioral Health. I understand I may revoke this authorization at any time. To revoke this authorization, I will send a written notification to Valley Behavioral Health's Medical Records Department. 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 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 program, both minor and parent/ guardian must sign the form. A "Foster Parent" is not the legal guardian and cannot sign the 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: 8412 Fax# 801-424-4043

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