Authorization
To Use and Disclose Protected Health Information (PHI)
ALL fields are required to be completed

Member Name: _____ DOB: _____
Address: _____ ☐ HOMELESS
City: _____State: _____ Zip: _____
Home # _____ Cell #_____

Summit County Clubhouse follows federal and state confidentiality regulations prohibiting release of information about you without your permission or as otherwise permitted or required by law. Substance Abuse Disorder (SUD) treatment records have additional privacy protections (42 CGR Part 2) I understand that use and disclosure means sharing of my medical records including verbal, written and electronic communications. I give permission for Summit County Clubhouse and the person/organization listed below to share my medical, mental health, behavioral health, and/or substance abuse treatment records. Summit County Clubhouse does not re-disclose PHI received from 3rd party providers, entities, and/or agencies, except where required by law. Signing this form is voluntary and not required for membership at Summit County Clubhouse. I understand I may revoke this authorization at any time. To revoke this authorization, I will complete and submit Summit County Clubhouse's written revocation form. 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.

*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.

NAME OF THE AGENCY REQUESTING: Summit County Clubhouse
6304 Highland Drive
Park City, UT 84098
(801) 930-0277
referrals@summitcountyclubhouse.org

Attn: _____
Email:_____

NAME OF THE AGENCY OR PERSON AUTHORIZED to RELEASE/DISCLOSE:

Agency/Name: _____ Attn: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____
Fax #: _____ Email: _____

PURPOSE

X Probation X Legal/Court ☐ Employment	X Coordination of Care (referral, treatment plan, mental health/psychiatric evaluation) ☐ School ☐ Benefits & Eligibility/Coordination

EXIPIRATION

☐ 1x disclosure ☐ _____ (specific timeframe)	X End of or inactive membership at Summit County Clubhouse

Member Signature: _____ Date: _____
Witness Signature: _____ Date: _____