UTAH COUNTY
HEALTH DEPARTMENT

PATIENT AUTHORIZATION TO PERMIT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
In Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

I, _____, _____, (date of birth)_____
(printed full name) (maiden name if applicable) (MM/DD/YEAR)
give permission to the **Utah County Health Department (UCHD) to disclose** the following information:

☐ My selected health records; or ☐ My minor child's health records (**EXCEPT** STI Records):

Name of minor child:_____Birthday of minor child: _____
(MM/DD/YEAR)

Initial all that apply:

Initials	Record Type	From: Month/Year:	To: Month/Year
	Immunization records		
	Lab results		
	Immigration records		
	Physical exam records		
	TB testing and/or treatment records		
	Women's health/cancer screening records		
	Sexually Transmitted Infection (STI) records		
	Other:		

(Note: some records are destroyed after a certain number of years and are no longer available.)

UCHD may disclose this health information to the following recipient:
Name (or title) and organization (if applicable):_____
Address: _____
City: _____State: _____Zip: _____
Phone:_____ Email: _____
Relationship to me:_____ Fax: _____
The purpose of this authorization is (please be specific):

_____

This authorization ends:
☐ - On (date): _____
☐ - When the following occurs (e.g., specific age, situation, or death): _____

I understand that I may revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I also understand that any disclosure made is bound by the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 & 164, and that recipients of this information may **NOT** redisclose this information unless otherwise provided for in the regulations.

☐ I acknowledge I have been given the opportunity to review the UCHD Notice of Privacy Practices.

Signature: _____**Date:** _____

Signature of Parent, Guardian,
or Authorized Representative: _____**Date:** _____

Requestor's Printed Name: _____

Requestor's Signature: _____

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If I am unable to make this request in person showing my personal identification (ID), I have faxed*, or emailed**, **along with a copy of my current, legal, photo ID,** this completed request to Utah County Health Department. **NOTE: The security of any documents sent by email or fax is not guaranteed.**

OR:

I have verified my ID with a Notary Public as noted below and faxed* or emailed ** this request to Utah County Health Department.

STATE OF _____)

COUNTY OF _____)

On this _____day of _____, 20___, personally appeared before me _____the signer of the above instrument, who duly acknowledged to me that they execute the same.

My Commission expires: _____
NOTARY PUBLIC

***Fax Number for Utah County Health Department (UCHD): 801-851-7055**

****Email: lisath@utahcounty.gov**

Patient, Parent, Guardian, or Authorized Representative requests that UCHD send the requested records to one of the following:

- ☐ **Fax number:** _____
- ☐ **Email Address:** _____
- ☐ **USPS Mailing Address listed on the first page.**

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____

***** Confidentiality Notice *****

The information in this fax or email may be confidential and/or privileged. This fax or email is intended to be reviewed by only the individual or organization named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, or copying of this fax or e-mail and its attachment, if any, or the information contained herein, is prohibited. If you have received this fax or e-mail in error, please immediately notify the sender by return fax or e-mail and delete/destroy this information.

Form updated 1/9/2026