To prevent delay in processing your request, please include a copy of a government issued photo ID (i.e. a driver's license) for verification of signature.

PROVO CANYON SCHOOL

New Custodian of Records for this UHS-BH Facility
Universal Health Services - Nashville Regional Office
Phone: 615-312-5834 - Fax#: 615-997-1200
Email: nrorecordsrequests@uhsinc.com

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION (FORM CDCI)

Patient's Name:_____ **Date of Birth** _____

I hereby ☐ AUTHORIZE or I hereby ☐ REQUEST disclosure of confidential medical and mental health Information in accordance with the terms and conditions set forth below.

Information requested from:

Provo Canyon School
4501 North University Ave.
Provo, UT 84604
Or
763 N. 1650 W.
Springville, UT 84663

Information to be released to:

_____
_____
_____
_____
_____

Purpose of disclosure:

☐ Continuation of Care

☐ Other: Specify _____

Extent or nature of the information to be disclosed: Please put **YOUR INITIALS** in the boxes that apply:

☐ Discharge Summary
☐ Treatment plan Reviews
☐ History & Physical
☐ Psychiatric Evaluation
☐ Psychosocial Assessment
☐ Other _____

Any information obtained will not be released by the above-named person or organization to any other person or organizations unless I so authorize.

IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2)

I hereby also consent to the release of any and all alcohol and/or drug abuse treatment records under the same conditions outlined below. I understand that such information cannot be released without my consent, except under special circumstances.

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (Must Specify)

Date_____

Event _____

Condition _____

Signed this _____day of _____, 20_____.

_____
Patient's Signature Date

_____
Witnessed by Date

To facilitate compliance with HIPAA and FERPA Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 DFS 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder.

Once requested Protected Health Information (PHI) is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient rediscloses it.

_____
Parent/Guardian Signature Date
(for minor or incompetent patient)

WRITTEN SUMMARY OF FEDERAL LAW AND REGULATIONS

Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing

2. The disclosure is allowed by a court order; or

3. The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation.

Violation of the Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal laws and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities.