REQUEST FOR PROTECTED HEALTH INFORMATION UNDER HIPAA

Salt Lake County Jail ♦ 3415 South 900 West ♦ Salt Lake City, UT 84119 ♦ 385-468-8600 ♦ FAX 385-468-8722 or 801-266-8931 ♦E-Mail: ADC-MedicalRecords@saltlakecounty.gov

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE
PHONE	FAX/EMAIL/PHONE

Information to be Used or Disclosed

Specific Time Period From (DD/MM/YY) _____ To (DD/MM/YY) _____

The information to be provided from my health record: (check appropriate box(es)

- ☐ Sick Call
- ☐ Mental Health Diagnosis/Treatment
- ☐ Medical Diagnosis/Treatment
- ☐ HIV/AIDS Related Treatment
- ☐ Other
- ☐ Entire Record
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Labs, X-rays, and Ultrasounds
- ☐ Medications/Prescriptions

Other (Specify) _____

Purpose of Disclosure

☐ Legal ☐ Second Opinion ☐ Disability ☐ At the request of the individual ☐ Speak to

Other (please specify) _____

I understand that I may revoke this authorization in writing submitted at any time to the Salt Lake County Sheriff's Office; Corrections Bureau; 3415 South 900 West; SLC, UT 84119, except to the extent that action has been taken in reliance on this authorization. This authorization will expire after the request has been fulfilled, unless a different expiration date or *expiration event* is stated.
(Specify new date) _____

I understand that Salt Lake County ADC will not condition treatment or eligibility for care on my providing this authorization, except if such care is provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

I understand that there will be a charge for copy costs of .50 cents per page. The Sheriff's office does not waive costs for HIPAA requests for prisoners. I understand that my request will be fulfilled within 30 days.

Signatures

NAME OF PATIENT (Print or type)	SO #
PATIENT'S DOB	PATIENT'S SS#
SIGNATURE OF PATIENT	DATE
WITNESS	MIS#

Notary Required for Third Party Request

State of: _____

County of: _____

I certify that _____, who is known to me or who has presented satisfactory identification, has, while in my presence and while under oath or affirmation, voluntarily signed this document and declared that it is true.

Date: _____ Sign here: _____

My commission expires: _____

Notary Seal:

Medical Care Provider Use Only

☐ Continuity of Care

For Office Use Only

Date Request Filled:	By:
Identification Presented:	Fee Collected: