AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize **SSM Health** to release

the information described below to: **UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541**

Individual's full name: _____

Address: _____

Phone #: _____Date of Birth: _____

Information to be disclosed:
Results of Blood work taken at the JC Schools Health Screen will be the only biometric uploaded to UMR.
Read Carefully:

- I understand that my medical/health information records are confidential. The protected health information (PHI) in my medical record may include mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
- **I understand that by signing this authorization, I am allowing the release of the total number of biometric targets satisfied resulting from the following tests: A complete panel of a total blood workup includes: Fasting blood sugar, total Cholesterol, and more.** This authorization includes information presently compiled and information to be compiled during the course of treatment by the above-named facility.
- This authorization becomes effective on the date originally signed. This authorization automatically expires one year from the effective date.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so IN WRITING and present my written revocation to the SSM Health group Privacy Officer. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected.
- I understand that I have a right to receive a copy of this authorization. A photographic copy of this authorization is as valid as the original.
- I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I may contact the Privacy Officer for the covered entity releasing the records.

My signature below acknowledges that I have read, understand and authorize the release of the information described above.

_____ _____
Signature of Patient or Legal Representative Date

If signed by a Legal Representative, please describe the authority of the Legal Representative to sign for

Patient:_____.