RELEASE OF INFORMATION

CONSENT FOR RELEASE OF WORK RECORDS; MEDICAL RECORDS; MENTAL HEALTH TREATMENT RECORDS PURSUANT TO UTAH CODE ANN § 58-60-114 & 509; PSYCHOTHERAPY NOTES PURSUANT TO HIPAA AT 45 CFR 164.508(2); AND DRUG AND ALCOHOL TREATMENT RECORDS PURSUANT TO 42 U.S.C. § 290dd-2 AND 42 CFR PART 2

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(Applicant/Participant First Name) (Middle Name) (Last Name) (Degree)

hereby authorizes **Utah Professionals Health program (UPHP)** to receive and/or release all information concerning my relationship with the organizations listed below including disclosure of any and all types records regarding my work performance, regular medical treatment, mental health (including psychotherapy notes) treatment, drug and alcohol treatment, and substance use disorder treatment, including but not limited to, diagnosis, test results, treatment, vital signs, medications administered, prognosis, behavior, condition, vital statistics, personal contact and identification information, insurance and payment information, advisories and notices, ongoing status in a mental health and/or drug and alcohol treatment program, and communications about me to the **Utah Professionals Health Program (UPHP).**

_____	_____	_____
Name	Address	Telephone number
_____	_____	_____
Name	Address	Telephone number
_____	_____	_____
Name	Address	Telephone number

I understand that disclosure of the request information will be for the purposes of administering the health program, including monitoring my work performance; evaluating my compliance with my program contract; monitoring and evaluating my mental and physical condition, and all other functions of the health program

I understand that the records, including mental health, psychotherapy notes, drug and alcohol treatment, and substance use disorder treatment records, may be submitted as evidence in administrative, civil, and/or appellate proceedings and courts.

I hereby waive any physician-patient privilege and mental health therapist-patient privilege pursuant to Utah Rules of Evidence 501 & 506; Federal Rule of Evidence 501, and any state and federal common law, to permit such release of records to the Division for the purposes described above.

I understand that I may decide not to sign this authorization. The providers above will not deny me treatment solely for that reason. I understand that I may consult with legal counsel before signing this release and consent form.

I also understand that this consent is subject to revocation at any time, except to the extent that the program or person which is to make the disclosure has already taken action in reliance upon it. To revoke this authorization, I will send a revocation in writing to each of the providers listed above. If not previously revoked, this consent will terminate upon my termination from the Utah Professionals Health Program.

_____	_____
Signature	Date Signed

Birth Date: _____ Address: _____

City: _____ State: _____Zip _____ Telephone Number: _____