wasatch pediatrics

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Phone #: _____

I AUTHORIZE THE FOLLOWING ORGANIZATION TO RELEASE INFORMATION FROM THE PATIENT'S MEDICAL RECORD AS STATED BELOW.

INFORMATION TO BE RELEASED *FROM*	INFORMATION TO BE RELEASED *TO*
☐ Wasatch Pediatrics ☐ Organization/Person Name:	☐ Wasatch Pediatrics ☐ Organization/Person Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone # Fax #	Phone # Fax #

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY) *ONLY LAST 2 YEARS OF RECORD WILL BE SENT UNLESS SPECIFIED*	
☐ History & Physical / Consult	☐ Radiology Reports
☐ Labs	☐ Results
☐ Progress Notes	☐ Immunizations
☐ Behavioral Health	☐ Other (Please Specify):
☐ Entire Medical Record for Specified Date Range: _____ to _____	
Format of Request ☐ Paper ☐ CD (If not selected, records will be sent in CD format)	

PURPOSE OF RELEASE	
☐ Legal	☐ Personal Use
☐ Continuing Care	☐ Transfer to Another Provider
☐ School	☐ Other (Please Specify):

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency Syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use.
- 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 health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date, the authorization will expire in 60 days.
- Authorizing this disclosure of health information is voluntary. I can refuse to sign authorization. I need not sign this form in order to assure treatment. I understand that I may inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR § 164.524. I understand that when health information is released, the information could be re-disclosed by the third-party receiver and may no longer be protected by federal or state privacy laws.

_____ _____

Parent/Guardian Signature Date

_____

Printed Name