GRANGER MEDICAL CLINIC

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

****THERE MAY BE A FEE FOR MEDICAL RECORDS****

This authorization complies with all state and federal regulations and MUST BE COMPLETED IN ITS ENTIRETY to be valid. To ensure added security we DO NOT FAX medical records.

Patient Name _____ DOB (month/day/year) _____

Address _____ Phone Number _____

City _____ State _____ Zip Code _____

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RELEASE MEDICAL RECORDS FROM:

Name of Clinic/Provider _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

RELEASE MEDICAL RECORDS TO:

Name of Company/Agency/Facility/Person _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

INFORMATION TO BE RELEASED: HIPAA laws prohibit disclosure of other facility records, including: hospital records, other clinic records, and medical records sent to us by physicians on your behalf.

☐ Lab ☐ X-ray ☐ Progress Notes ☐ All ☐ Written: _____

Date(s) of Treatment(s) to Disclose _____ Purpose of Disclosure (e.g. continuing care, school, legal, etc.) _____

☐ I consent to the release of information, which may relate to alcohol/drug abuse or contain: psychiatric information, HIV or Sexually Transmitted Disease testing results, or AIDS information.

Initials: _____

This authorization is valid for 1 year from the date of signing and may be revoked at any time by sending a written request to the facility releasing your personal health information. Revocation of this authorization shall not affect releases made prior to the revocation.
I understand that signing this release is voluntary and that I need not sign this document in order to assume medical treatment by my provider. I further understand that the disclosure of this carries with it the potential for unauthorized re-disclosure and the information may no longer be protected by federal confidentiality laws.

Patient Signature (if over 18) _____ Date (month/day/year) _____

If patient is under 18, or unable to sign for themselves, please have parent, legal guardian, or representative fill out the below section:

Signature _____ Printed Name _____ Relationship to Patient _____

PLEASE NOTE: A fee will be charged to the patient when they request their records be sent to a third-party requester (e.g. attorney or insurance). However, no fee will be charged if sent to another continuing care provider (e.g. other physician, hospital, or clinic).

PROOF OF ID REQUIRED TO RELEASE MEDICAL RECORD

☐ ID COPIED AND ATTACHED TO THIS RELEASE FORM (copies of both parties' ID – patient and recipient)

Recipient Signature: _____

Granger Medical Records - Phone: 801.965.3471 Fax: 801.965.3537