**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

**(This authorization complies with HIPAA)**

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| --- | --- |
| Printed Name of Patient (first, middle, last name)   | Birthdate (mm/dd/yyyy)  |
| Address(Street Address, City, State, Zip Code)   |
| Phone Number | E-mail |

|  |
| --- |
| Printed Name of Guardian or Legal Representative (first, middle, last name)   |
| Address(Street Address, City, State, Zip Code)   |
| Phone Number |  E-mail |

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

|  |
| --- |
| Person/Organization to Release InformationLegacy Point Family Medicine |
| Street Address81 North 2000 West |
| City West Point | State Utah | Zip Code84015  |
| Phone Number 801-614-5140 | Fax Number801-614-5144 |

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

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| Person/Organization to Receive Information  Heart and Soul Family Medicine; Sara Arrington, FNP |
| Street Address  3110 West 300 North, Suite A |
| City West Point | State Utah | Zip Code 84015 |
| Phone Number 385-393-8224 | Fax Number385-393-8225 |

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from 2007 to 2017 may be released:

* Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
* Patient Histories
* Office Notes (except psychotherapy notes)
* Test Results
* Radiology Studies
* Films
* Referrals
* Consults
* Billing Records
* Insurance Records
* Records Sent by Other Health Care Providers

I further understand that my medical record may include one or more of the following:

* Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
* HIV-Related Treatment
* Mental Health Information or Psychological Conditions
* Alcohol or Substance Abuse Treatment
* Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

□ Change of Doctor

□ Individual Request

□ Specialist Referral

□ Workers Compensation

□ Insurance Purposes

□ Continued Treatment

□ Legal Investigation

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law. This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

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| Signature of Patient or Personal Representative:  | Date Signed:  | Description of Personal Representative’s Authority: |