

Request For Release Of Records Authorization Form

You are entitled under federal law to access your protected health information maintained in a "designated record set". In order to process your request for access to this information, please complete this form. If you have any questions or concerns please contact the Privacy Officer at 801-443-1171.

To From **Tricity Medical Clinic, Inc.**
830 North 2000 West Pleasant Grove, Utah 84062
Fax # 801-756-1705 Phone 801-756-3511

To From _____
Name of Company/ Agency/ Facility/ Person

Address City

State Zipcode Phone Fax

I would like a copy of my protected health information. I understand that I may be charged a fee for the copies, postage, or facsimile fees.

Patients Full Name _____
Social Security Number _____
Patients Birthdate _____
Patients Address _____
Patients Phone Number _____

I authorize the following information to be released:

Immunizations _____ Hospital Records _____
Lab Reports _____ Other _____
X-Ray Reports _____
Office Notes _____

Patients Full Name _____
Social Security Number _____
Patients Birthdate _____
Patients Address _____
Patients Phone Number _____

I authorize the following information to be released:

Immunizations _____ Hospital Records _____
Lab Reports _____ Other _____
X-Ray Reports _____
Office Notes _____

Reason for release of records _____

The purpose of this disclosure/authorization request Patient request Treatment Payment other _____

This authorization will remain effective for 90 days unless earlier date or condition/event is specified here:

I understand that:

Once Tricity Medical Clinic, Inc discloses my health information by my request, it cannot guarantee that recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information..

This authorization will remain in effect until the authorization expires or I provide a written notice of revocation to Tricity Medical Clinic, Inc.

I can specify which records may be released.

The Provider is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that the Provider may extend the deadline by an additional thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

Signature of patient or legal representative

Relationship to patient

Date

If patient is minor Full Name of Parent requesting records _____
(Please Print)