REQUEST FOR MEDICAL RECORDS

(Disclosure of Protected Health Information (4/13/03))

PATIENT:_____

DOB:_____

DATE OF REQUEST:_____ REQUEST EXPIRATION DATE:_____

RECORDS REQUESTED:_____

RECORDS TO BE OBTAINED FROM: (Get records from) Transfer of Care? YES NO (circle one)

PRACTICE/DOCTOR:_____

_____

ADDRESS:_____ City:_____ ST:_____

ZIP:_____

PHONE:_____

FAX:_____

RECORDS TO BE SENT TO: (Send records to)

PRACTICE/DOCTOR:_____

_____

ADDRESS:_____ City:_____ ST:_____

ZIP:_____

PHONE:_____

FAX:_____

Right to terminate or revoke authorization: You may revoke or terminate this authorization by submitting a written revocation to South Routt Medical Center. You should contact the Privacy Official to terminate this authorization.

Potential for re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to protection of the privacy of this information once South Routt Medical Center discloses it to another party.

Rights of the Individual: You have the right to contact and request that your information be protected from anyone that you release your health information to.

Effect of refusing authorization: If you refuse to sign this authorization, South Routt Medical Center will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

PATIENT SIGNATURE:_____
DATE:_____
PARENT/GUARDIAN SIGNITURE:_____
DATE:_____