2121 N 1700 W Layton, UT 84041
records@tannerclinic.com
(801) 773-4840 Ext. 3753 – Office (801) 525-8194 - Fax

Authorization for Disclosure of RADIOLOGY STUDIES from Tanner Clinic

** ONE PATIENT PER REQUEST FORM. EACH PATIENT REQUEST IS TO BE MADE SEPARATELY **

IMPORTANT - Please Read

Pricing and Pick-Up Information for Patients:

- HIPAA guidelines define patient records, including radiology studies, as protected and cannot be disclosed without written permission.
- CDs containing studies are charged at $25.00 each and $15.00 for each additional CD.
- Referrals to other physicians are at no charge. Referral physicians' name, facility name, and basic address is required.
- All studies acquired at the Layton Tanner Clinic facility are automatically made available for all other Tanner Clinic physicians.
- Please allow 2 business days to prepare requested studies for their intended destination.
- **An additional $15.00 charge for same day requests (studies processed for release within 24 hours) may be assessed.**
- **All areas of this form must be filled out for personnel to assist you in your request for records.**
- **Picture I.D. and full payment for studies required at time of pick-up.**

Request for Disclosure of Radiology Studies of:

NAME OF PATIENT _____ Medical Record#_____
Address _____ Phone #_____
City, State, Zip _____
Date of Birth _____

Type of Study and When Performed: _____

Physician who ordered the Study: _____

Reason for Disclosure:

□ To be sent to doctor by Tanner Clinic □ Military Transfer □ For Own Use **(Fee applies)** □ Other_____ **(Fee applies)**

To Be Disclosed To (if different from Patient listed above):

Name: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Relationship to Patient: _____

I hereby release the above-named facility or doctor(s) from all legal liability that may arise from the release of this information. I acknowledge that records to be released may include material that is protected by Federal Regulation 42 CFR, Part 2. My signature below authorizes the release of all requested information. Such authorization may be revoked in writing at any time. Disclosed information may be subject to redisclosure by the recipient. A separate authorization is generally required with each release.

(Please sign UPON RECEIPT of records)

_____
Signature of Patient Requesting Studies
(or representative & relation to patient if a minor)

_____
Signature of Person Receiving Studies
(or representative & relation to patient if a minor)

_____
Print Name of Patient
(or representative & relation to patient if a minor)

_____
Date of Images are Released from Tanner Clinic

_____
Date of Request

Type of I.D. Checked: □ Driver's License
□ Other_____

_____
Signature of Clinic Staff **Accepting** Request for Studies

_____
Signature of Clinic Staff **Issuing** Studies

□ ***Pick Up*** □ ***Fax*** □ ***Mail***

For Tanner Clinic Use Only *(Attn Patty):*

Amount Due $ _____ **Invoice #** _____

Paid by: □ Check □ Cash □ C.C. T.C. **Staff Initials** _____

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