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

Authorization for Disclosure of Protected Health Information From Outside Facility

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

All areas of this form must be filled out in order for us to assist you in your request for records

I HEREBY AUTHORIZE THE DISCLOSURE OF THE HEALTH RECORDS OF:

Name of Patient: _____ **Date of Request:** _____

Address: _____ **City**: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Last 4 Digits of Social Security #** _____ **Phone #** _____

Information Requested:	**For Which Date(s):**	**For Which Doctor(s):**
□ Lab Reports	_____	_____
□ X-Ray - MRI - CT Reports	_____	_____
□ Office Visit Notes	_____	_____
□ Cardiac Reports (EKG/Stress)	_____	_____
□ Operative Reports	_____	_____
□ History & Physical	_____	_____
□ Other _____	_____	_____
_____	_____	_____

Records are to be Disclosed From:

Name of Clinic/Doctor _____ **Phone #**_____

Address _____ **Fax #**_____

City, State, Zip _____

Records are to be Disclosed To: **Tanner Clinic**
Attn: Medical Records
2121 N 1700 W
Layton, UT 84041 (801)773-4840 Fax: (801) 525-8194

Please Note - ***In the spirit of mutual professional courtesy, Tanner Clinic neither charges nor pays for records released between medical professionals.***

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, including AIDS/AIDS Testing information, drug/alcohol information, and mental health information. My records are protected and cannot be disclosed without my written permission. I may make a request in writing at any time to this facility to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR§164.524. 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. Recipient has the right to permanently retain all, part, or none of the information received from the above-named facility or doctor(s). Unless otherwise requested by patient, outside records received by Tanner Clinic are subject to review for whole, part or no retention by the receiving physician based on determination of applicable need for retention.

_____ _____

Signature of Patient Requesting Records (or representative if a minor) **Patient Chart Number**

_____ _____

Print Name of Patient or Representative & Relation to Patient **Signature of Clinic Staff Accepting This Request**

(Rev 10-21-15)