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 Tanner Clinic

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

Pricing and Pick-Up Information for Patients:

- HIPAA guidelines define patient records as protected and cannot be disclosed without written permission.
- Patients may have the first 20 pages copied without charge.
- Additional sheets will be $7.00 (retrieval fee), plus .15 per page. Shipping and handling and tax may apply.
- Doctor to doctor releases are done without charge. All other requested reasons usually carry a charge.
- Please allow 4-5 business days to prepare requested records for their intended destination.
- **An additional $8.00 charge for same day requests (records received within 24 hours) may be assessed.**
- **All areas must be filled out for personnel to assist you in your request for records.**
- **Picture I.D. and full payment for records required at pick-up.**

Request for Disclosure of Health Records of:

Name of Patient _____ Medical Record#_____
Address _____ Phone # _____
City, State, Zip _____ Last 4 Digits of SSN _____
Date of Birth _____

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

Reason for Disclosure:

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

Records Are To Be Disclosed To:

Name_____ Phone # _____
Address_____ Fax#_____
City, State, Zip _____ Date Records Required _____
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, including AIDS/AIDS Testing information, drug/alcohol information, and mental health information. 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.

_____ _____
Signature of Patient Requesting Records (or representative & relation if patient is a minor)

_____ _____
Signature of Patient Receiving Records (or representative & relation if patient is a minor) ***(Please sign UPON RECEIPT of records)***

_____ _____
Print Name of Patient (or representative & relation if patient is a minor) Date of Receipt

_____ Type of I.D. Checked: ☐ D.L. ☐ Other_____
Date of Request

_____ _____
Signature of Clinic Staff **Accepting** This Request Signature of Clinic Staff **Issuing** Records

☐ ***Pick Up*** ☐ ***Fax*** ☐ ***Mail***

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

Amount Due $ _____ **Invoice #** _____

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

Rev. 14-OCT-11