TANNER CLINIC
P.O. Box 337 Layton, UT 84041
records@tannerclinic.com
(801) 773-4840 Ext. 3369 – 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 **

HIPAA guidelines define patient records as protected and cannot be disclosed without written permission. The patient is not required to sign this authorization in order to receive treatment, payment, enrollment in a health plan, or eligibility for benefits. This authorization expires upon fulfillment of this request.

>> **Allow up to 7 business days for your request to be processed** <<

All necessary information, including signature and date, must be filled out in order to fulfill your request*

Request for Disclosure of Health Records of:

Name of Patient _____ Date of Birth_____
Previous other name, maiden name, etc _____ Phone # _____
Address _____ Email_____
City, State, Zip _____

Date Range: Select only *ONE* option: (If left blank, will release last 1 year)

□ **All Records Last 1 Year** □ **All Records Last 2 Years** □ **All Records Last 5 Years** □ **Dates:___/___/___ to ___/___/___**

Information Requested:

□ **Immunizations Only**

Specify Doctor/Specialty

□ Office Visit Notes _____
□ Lab Reports _____
□ Cardiac Reports (EKG, Stress) _____
□ Surgical Reports _____
□ Reports –X-Ray, CT, MRI _____
□ Other _____ □ Images –X-Ray, CT, MRI _____

Reason for Disclosure:

□ To Be Sent to Another Doctor □ Insurance □ Legal □ Military Transfer □ For Own Use □ Other_____

Records Are To Be Disclosed/Sent To:

Name_____ Phone # _____
Address_____ Fax #_____
City, State, Zip _____ Email_____
Relationship to Patient _____

Media Preference (Select only *ONE*)*: ☐ ***Paper*** ☐ ***Digital*** (*Emailable*) ☐ ***Digital*** (on *CD*)

* Notice: All requests resulting in over 250 pages will *not* be printed on paper – they will be placed on a CD or emailed as a digital file

Method of Disclosure (Select only *ONE*): ☐ ***Pick Up*** » Specify***: Layton or Kaysville*** ☐ ***Email*** ☐ ***Mail*** ☐ ***Fax***

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 HIV/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 by contacting Tanner Clinic Medical Records. Disclosed information may be subject to redisclosure by the recipient and may no longer be protected by HIPAA regulations.

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

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

_____
Date of Request

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

FOR OFFICE USE ONLY: MRN_____

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

_____
Date of Receipt

_____
Signature of Clinic Staff Issuing Records

Type of I.D. Checked: □ D.L. □ Other_____