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 To Be Disclosed To Tanner Clinic

** ONE PATIENT PER REQUEST FORM. THIS AUTHORIZATION EXPIRES UPON FULFILLMENT OF THIS REQUEST **

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 HEALTH RECORDS OF:

Name of Patient: _____ **Date of Birth:** _____

Previous Other Name, Maiden Name, etc:_____

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

Phone #: _____

Information Requested:	**For Which Date(s):**	**For Which Doctor(s):**
☐ Immunizations	_____	_____
☐ Labs	_____	_____
☐ X-Ray - MRI - CT Reports	_____	_____
☐ Office Visit Notes	_____	_____
☐ Cardiac Reports (EKG/Stress)	_____	_____
☐ Operative Reports	_____	_____
☐ Other _____	_____	_____

Records are to be Disclosed/**Released From:**

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

Address _____ **Fax #**_____

City, State, Zip _____

Records are to be Disclosed/**Sent To:**

Tanner Clinic
Attn: Medical Records
P.O. Box 337
Layton, UT 84041
Fax: (801) 525-8194
Email: records@tannerclinic.com

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

My records are protected and cannot be disclosed without my written permission. I am not required to sign this form in order to receive treatment, payment, enrollment in a health plan, or eligibility for benefits. 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. 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 by contacting Tanner Clinic Medical Records. Disclosed information may be subject to redisclosure by the recipient and no longer protected by HIPAA regulation. 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) **Date of Request**

_____ _____
Print Name of Patient (or Representative & Relation to Patient) **Signature of Clinic Staff Accepting This Request** (Rev 07-20)