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.

>> Please allow at least 7 business days for your request to be processed <<

All necessary information, including signature and date, must be filled out and legible 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 ________________________________

Information Requested:

☐ **Medical Records**
Date Range: (Select only *ONE* option below):

- ☐ **All Records Last 1 Year**
- ☐ **All Records Last 2 Years**
- ☐ **All Records Last 5 Years**
- ☐ **Limited – Specific Record Type / Date Range**
  - ○ Office Visit Notes Date ____________
  - ○ Lab Reports Date ____________
  - ○ Cardiac Reports (EKG, Stress) Date ____________
  - ○ Surgical Reports Date ____________
  - ○ X-Ray, CT, MRI Reports Date ____________
  - ○ Other ____________ Date ____________

☐ **Behavioral Health / Mental Health Records**

Date Range ________________________

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 ________________________________

Method of Disclosure **(You must select only Digital Copies *or* Paper Copies – not both):**

Digital Copies: ☐ **1. Email** ☐ **2. Patient Portal** *(You must already be enrolled in Patient Portal)* ☐ **3. Other** ____________

OR

Paper Copies: ☐ **1. Pick up** >> Available ***only*** at Kaysville Tanner Clinic ☐ **2. Mail** ☐ **3. Fax**

* **Notice:** All requests resulting in **over 200 pages** will ***not*** **be printed on paper** – they will be digitally generated

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, except to the extent action has been taken in reliance thereon. 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

Feb '24

WHEN PICKING UP RECORDS: MRN ____________

____
Signature of Patient **Receiving/Picking Up** Records
(or personal representative & relation if patient is a minor)

____
Date of Receipt of Records

____
Signature of Clinic Staff Issuing Records

Type of I.D. Checked: ☐ D.L. ☐ Other ____________