alpinemedicalgroup

www.alpinemedicalgroup.com

AUTHORIZATION TO RELEASE AND/OR RECEIVE PROTECTED HEALTH INFORMATION

Internal Medicine: (801) 328-1260

This authorization must be written, dated, and signed by the patient or by the person authorized by law to give authorization. If the individual completing this form is the legal guardian, has legal custody of, or has power of attorney for the patient, the legal document indicating authorization must accompany this request. Completion of this form is voluntary. However, refusal to release necessary medical information may affect eligibility for services.

I hereby authorize: (Person or entity that is releasing your information on this side)

NAME OF SENDING PERSON/ORGANIZATION

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

To disclose to: (Person or entity that is receiving your information on this side)

NAME OF RECEIVING PERSON/ORGANIZATION

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

Records and information pertaining to:

FULL NAME OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

MEDICAL RECORD NUMBER DAYTIME PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

Type:

- ☐ Paper
- ☐ Electronic
- ☐ Verbal
- ☐ Exchange between both parties above

Distribution:

- ☐ Fax number _____
- ☐ Mail to address above
- ☐ Pickup
- ☐ In person
- ☐ Telephone
- ☐ Testimony/Deposition

The released information will be used for the following purpose(s):

☐ Personal Copy ☐ Continuity of Care ☐ Insurance ☐ Legal/Attorney ☐ Worker's Compensation From_____To_____ ☐ Other

☐ **CHART NOTES** *From*_____ *To*_____

☐ **PATHOLOGY REPORTS** *Date(s)*_____ *Name/Type of Test(s)*_____

☐ **LABORATORY RESULTS** *Date(s)*_____ *Name/Type of Test(s)*_____

☐ **X-RAY REPORTS** *Exam(s)/Date(s)*_____

☐ **GENETIC TESTING INFORMATION** *From*_____ *To*_____ *Signature*_____ *Date*_____

☐ **HIV/AIDS RECORDS & RESULTS** *From*_____ *To*_____ *Signature*_____ *Date*_____

☐ **SEXUALLY-TRANSMITTED DISEASE** *From*_____ *To*_____ *Signature*_____ *Date*_____

☐ **MENTAL HEALTH INFORMATION** *From*_____ *To*_____ *Signature*_____ *Date*_____

☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (Specify): _____

☐ **BEHAVIORAL HEALTH INFORMATION** *From*_____ *To*_____ *Signature*_____ *Date*_____

☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (Specify): _____

☐ **DRUG/ALCOHOL RECORDS** *From*_____ *To*_____ *Signature*_____ *Date*_____

☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (Specify): _____

This authorization may be revoked at any time, except when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire six months from the date of signing or shall remain in effect for a period reasonably needed to complete the request. I request payment of authorized benefits made on my behalf for any services furnished to me by the above named providers. I authorize any holder of medical or other information about me to release to my insurance company and its agents any information needed to determine these benefits for related services. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

SIGNATURE INDICATE RELATIONSHIP DATE