GRANDVIEW
FAMILY MEDICINE
My Health, My Family, My Clinic-

1900 N. State Street • Provo, Utah 84604 • Phone (801) 373-2001 • Fax (801) 373-4748

Authorization to Disclose Private Health Information

Authorization to release the information of		Type of Records Requested (charges for copies may be applied)			
Full Name of Patient	**Date of Birth**	**All Records**	**Office Notes Only**	**Lab Results Only**	**Other**

☐ **Information to be released from THIS office to:**

Organization Name_____ Phone (____)_____ Fax(____)_____

Address_____ City_____ State_____ Zip_____

Reason for requesting records: Moving Office Location Transferring Care Other_____

☐ **Information to be RECEIVED from:**

Organization Name_____ Phone (____)_____ Fax(____)_____

Address_____ City_____ State_____ Zip_____

Provider seen at Grandview Family Medicine_____

The following information <u>WILL</u> be released unless you specifically prohibit it by initialing the relevant box(es) below:

☐ AIDS / HIV test results ☐ Substance / alcohol abuse ☐ Mental / Behavioral Health ☐ Genetic Information

This authorization will remain in effect:

Until the following date _____ -or- Until the following event occurs: _____

***Unless otherwise noted, this authorization will remain in effect 180 days from the date signed.**

I understand that:

• Once "<u>this facility</u>" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
• There is a $30 .00 research & retrieval fee if I request these records for my own personal use.
• I may make a request in writing at any time to Grandview Family Medicine 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 records are protected and cannot be disclosed without my written permission.

To be used if facility requests this authorization:

• I may refuse to sign or may revoke this Authorization at any time and that such refusal or revocation will not affect the commencement, continuation or quality of "<u>this facility's</u>" treatment of me, enrollment in the health plan, or eligibility for benefits.
• I make a request in writing at any time to Grandview Family Medicine to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524.

Signature of Patient or Legal Representative _____ **Date** _____

Relationship to Patient _____ Witness _____