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HIPAA Disclosure Authorization Form Release of Private Health Information

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I, _____, hereby authorize Grandview Family Medicine to
(Please Print)

disclose protected health information about me as described below.

1. The following person or class of persons may receive the disclosure of protected health information.

Name(s): _____	Relationship: _____
_____	_____
_____	_____
_____	_____

2. Specific information to be disclosed is: *(if blank, complete record will be disclosed)*

All Records _____ Vaccines _____ Office Notes _____ Lab Results _____ Rx Pick Up _____

3. I understand that if the person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
4. I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Grandview Family Medicine. However, if I do revoke this authorization my revocation will not affect any prior actions taken in reliance on my authorization.
5. This authorization will expire on ____/____/____ (MM/DD/YY); or upon the following event: _____.

I certify that I have read, signed and received a copy of this authorization.

Signature of Patient or Patient's Representative

Patient's Date of Birth

Date

Relationship of Representative to Patient

Representative's Date of Birth