GRANDVIEW
FAMILY MEDICINE
My Health, My Family, My Clinic

1900 N. State Street • Provo, Utah 84604 • Phone (801) 373-2001 • Fax (801) 373-4748
EMAIL: medicalrecords@gfmclinic.com

Authorization to Disclose Private Health Information

(Only one patient per form)

Authorization to release the information of		Type of Records Requested (charges for copies may be applied)			
Full Name of Patient	**Date of Birth**	**Last 3 Years**	**Office Notes Only**	**Lab Results Only**	**Other**

☐ **Information to be released from Grandview to:**

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

Address_____ City_____ State_____ Zip_____

Please specify delivery method: ☐**Fax** ☐**Email** ☐**Disc (mail)**

Reason for requesting records: Moving Office Location Transferring Care Other_____

☐ **Information to be RECEIVED from: Please fax or email the requested records back to Grandview Family Medicine**

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

Address_____ City_____ State_____ Zip_____

Medical Provider 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** _____