Premier Family Medical
Your family's medical home.

American Fork Office	Lehi Office	Saratoga Springs
226 North 1100 East	680 E. Main	1528 N.Commerce DR. Suite 204
American Fork, UT 84003	Lehi, UT 84043	Saratoga Springs, UT 84045
Phone: 801-341-6727	Phone: 801-768-1699	801-766-8427
Fax: 801-855-3847	Fax: 801768-4526	801-766-5657

Medical Records Release

MRN:_____ Date:_____
(Office Use Only)

_____
Name (Please Print) Date of Birth Address City State Zip

authorizes Premier Family Medical:

☐ Release medical information to: ☐ Obtain medical information from

_____ _____
Name Address

_____ _____ _____
City State Zip

_____ _____
Telephone Fax

The information released will be used for the following purpose: _____

I specifically authorize the release of the following: Entire Record Yes____ No____ only the items listed below:

____Visit/Encounter Notes ____Lab Report ____EKG Report ____X-Ray Report ____Operative Report
____ History and Physical ____Drug/Alcohol Abuse Treatment ____Psychiatric and Mental Illness Treatment
____Human Immunodeficiency Virus (HIV) Antibody Test, Results, and Treatment ____Chart Summary

Other - Specifically_____

Dates of service: from_____ to _____ (if left blank will release 2 years only)

I expressly and voluntarily authorize disclosure of the above medical record for the purposes stated above. I further Understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This authorization of release is in effect until_____, at which time this authorization to use or disclose Protected Health Information expires. If no date given, this authorization will expire in 60 days.

I understand that I have the right to revoke this authorization in writing by sending notification to:

Premier Family Medical Attn: Compliance Officer
226 North 1100 East
American Fork, UT 84003

Premier Family Medical will not condition my treatment or payment on whether I provide an authorization for the requested use or disclosure.

I understand I have the following rights: To inspect or copy the Protected Health Information to be used or disclosed or to refuse to sign this authorization.

_____ _____
Signature (Patient or Personal Representative) Date

_____ _____
(Please print name) Relationship to Patient

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MEDICAL RECORDS RELEASE POLICY

Dear Patient:

We have many requests from patients regarding information in their medical chart. We want to accommodate your request, especially in urgent situations, as expediently as possible.

You may be asked to sign a "release or request for information" form to allow us to send or request medical records.

In order to comply with the request for copies of your medical records, we may need to obtain authorization from your physician to release the information in your chart. If your physician is out of the office it may require waiting to obtain the authorization until he/she returns.

We are currently under contract with a private copying service, CIOX Corporation, who copies and bills for some medical records. Premier Family Medical charges $10.00 for the first 20 pages and $.10 per sheet per page thereafter.

To protect your privacy, only the actual patient or patient's guardian will be allowed to pick up the records. It is also necessary to have a photo identification card.

Any questions may be directed to our medical records department.

Thank you for your cooperation.

Premier Family Medical