Medical Records Request for Lehi, American Fork, Saratoga Springs & Eagle Mountain:
680 East Main
Lehi, UT 84043
Phone: 801-341-6727
Fax: 801-768-4526

Medical Records Release

MRN: _____ Date: _____
(Office Use Only)

_____
Name (Please Print) **Date of Birth**

_____
Address **City** **State** **Zip**

Authorizes Premier Family Medical to:

☐ Release medical information to: ☐ Obtain medical information from:

_____
Name **Address**

_____
City **State** **Zip**

_____
Telephone **Fax**

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

I specifically authorize the release of the following: Entire Record **Yes** ____ **No** ____ only the items listed below:
___ Visit/Encounter Notes ___ History & Physical ___ Lab Report ___ EKG Report ___ X-Ray Report ___ Operative Report
___ Drug/Alcohol Abuse Treatment ___ Psychiatric & Mental Illness Treatment ___ Human Immunodeficiency Virus (HIV) Antibody Test, Results, & Treatment ___ Chart Summary

Other - Specify _____

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

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 that action has already 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 is 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:
Attn: Compliance Officer - Premier Family Medical
680 East Main
Lehi, UT 84043

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

Premier Family Medical
Your family's medical home.

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 quickly as possible.

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

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
Medical Records
680 East Main
Lehi, UT 84043
Phone: 801-768-1699
Fax: 801-768-4526