Premier Family Medical
Your family's medical home.

Dear Patient,

Premier Family Medical has now added a new way for you to request medical records. You can now fill out the second page of this document on your computer and email it back to us. To help us ensure a timely response please the check box next to the office that you primarily go to for care. You can mail this document to the address listed below the office you select OR you can email this document to:

medicalrecords@premierfamily.net

□ American fork, Lehi, Saratoga Springs, and Eagle Mountain offices:

Premier Family Medical
Medical Records
275 West 200 North
Lindon, UT 84042
Phone: 801-768-1699
Fax: 801-768-4526

□ Pleasant Grove, Lindon, Orem/Vineyard and Mountain Point offices:

Premier Family Medical
Medical Records
830 North 2000 West
Pleasant Grove, UT 84062
Phone: 801-443-1333
Fax: 801-756-1705

MEDICAL RECORDS RELEASE POLICY

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,

Medical Records Department

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Authorization to Release Medical Records

Name of Patient	Date of Birth
Address (including City, State and Zip code)	
Email	Phone Number

If requesting records for a minor, please enter guardian information below:

Name of guardian or Legal Representative	Relationship to Patient
Address (including City, State and Zip code)	
Email	Phone number

I hereby authorize Premier Family Medical to:

□ Release medical information to □ Obtain medical information from

Hospital/Clinic/Physicians Name	
Address (including City, State and Zip code)	
Phone number	**Fax number**

For the purpose of (reason for disclosure):

□Referral to a specialist □ Workers Comp/Disability □ Legal
□Change of Doctor/Provider □Personal □ Other_____

I authorize the entity stated above to release of the following information:

□ **Entire record** □ Lab Results □ Operative Report
□ History and Physical □ EKG □ Diagnostic Testing
□ Progress Notes □ X-Ray Reports □ Chart Summary
□ Other:_____

I also authorize the release of the following Protected Health Information:

□ Drug/Alcohol Abuse Treatment
□ Human Immunodeficiency Virus (HIV) antibody test, results, and Treatment
□ Psychiatric/Mental Health Treatment

Dates of service to release records: _____ to _____ (If left blank, only two years will be released)

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: Medical Records Custodian - Premier Family Medical
830 North 2000 West
Pleasant Grove, UT 84062

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 Authorized Representative)	Date
Print Full Legal Name	Relationship to Patient