MEDICAL RECORDS RELEASE FORM

MEDICAL RECORDS | 380 WEST 100 NORTH | MONTICELLO, UTAH 84535
medicalrecords@sanjuanhealth.org | p: 435.587.1203 | f: 435.587.3004 | w: sanjuanhealth.org

By completing and signing this document, you authorize San Juan Health to release your protected health information (PHI) to you or the party designated. Unless otherwise noted, this authorization expires immediately upon the release of your PHI.

Patient Information

I, _____ (full patient name), do hereby authorize the release of my PHI (or PHI from someone I am authorized to act on behalf for) from San Juan Health, as directed on this form, to the party below.

Patient Address: _____ City: _____ State: _____ Zip: _____

Patient Contact | Phone: _____ Email: _____

Party to Release Information

☐ Myself/Same as Above

Party Name: _____

Party Address: _____ City: _____ State: _____ Zip: _____

Party Contact | Phone: _____ Fax: _____ Email: _____

PHI to Release

I authorize the release of (***check one***): ☐ All of my medical record **OR** ☐ My medical record as described below*

*If authorizing only parts of your medical record, please outline what you need released (e.g., dates, labs, etc.) and please note that we cannot email radiology images—a password-protected CD can be given:

How do you want the record? ☐ Email ☐ Mail ☐ In-Person ☐ Fax (#: _____)

Release Expiration

Unless you include a specific end date, this authorization expires as soon as we fulfill the request to the party you designated. If you would like to extend the expiration date of this release form, include an end date here (mm/dd/yyyy): _____

Other Information

You understand that by signing this medical release form that—except to the extent action has already been taken by San Juan Health based on your authorization—you may revoke or terminate this authorization at any time by written notice (mailed, faxed or emailed (see top of document for contact information). You also understand that PHI used or disclosed pursuant to this authorization may be subject to re-disclosure by the party and is protected by federal privacy laws and regulations.

Signature: _____ DOB: _____ Date: _____

Signature of Patient Representative (if applicable): _____ Relationship: _____ Date: _____

Print Name of Representative (if applicable): _____