AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Authorization to release the protected health information of:

Patient Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Date of Birth:_____

This Authorization is to release protected Health Information **TO/FROM (Please circle one):**

Name: Canyon Medical Group

Address: 1624 North 200 East Suite 160

City: Logan State: Utah Zip: 84341

Phone: 435.750.5599 Fax: 435.750.0861

This Authorization is to release protected Health Information **TO/FROM (Please circle one):**

Name:_____

Address:_____

City:_____State:_____Zip:_____

Fax:_____ We must have Fax # in order to send records. If over 5 pages, please mail the records.

Reason for records release:_____

Release the following information:

_____

_____

_____

This Authorization will remain in effect- Unless otherwise noted 180 days from the date signed.

I understand that:

1- **Once Canyon Medical Group disclosed my health information by my request, they cannot guarantee that the Recipient will not redisclose my health information.**

2- **I may make a request in writing at any time to Canyon Medical Group 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**

3- **This Authorization will remain in effect until the Authorization expires of I provide a written notice of revocation to the Medical Records Department. If I revoke this Authorization, Canyon Medical Group may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.**

To be used if Facility requests this Authorization:
I understand that:

1- **I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Canyon Medical Group's treatment of me.**

2- **I may make a request in writing at any time to Canyon Medical Group 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.**

If I have questions about the disclosure of my health information, I can contact the Medical Records Department.

Signature _____ **Date** _____

Please allow at least 7 business days to receive Medical Records, unless arrangements have been made.

For office use only:

Date Requested	
Date Sent	
Appointments cancelled	
Fees Collected	
Employee Initials	