2121 N 1700 W Layton, UT 84041
records@tannerclinic.com
(801) 773-4840 Ext. 3753 – Phone
(801) 525-8194 – Fax

Authorization for Disclosure of Protected Health Information From Outside Facility

** ONE PATIENT PER REQUEST FORM. EACH PATIENT REQUEST IS TO BE MADE SEPARATELY **

All areas of this form must be filled out in order for us to assist you in your request for records

I HEREBY AUTHORIZE THE DISCLOSURE OF THE HEALTH RECORDS OF:

Name of Patient: ____

Address: ______________________________________ **City**: _____________ **State:** _______ **Zip:** ________

Date of Birth: _________________ **Last 4 Digits of Social Security #** __________ **Phone #** _______________

Information Requested:	**For Which Date(s):**	**For Which Doctor(s):**
☐ Lab Reports	____________________	____________________
☐ X-Ray - MRI - CT Reports	____________________	____________________
☐ Office Visit Notes	____________________	____________________
☐ Cardiac Reports (EKG/Stress)	____________________	____________________
☐ Operative Reports	____________________	____________________
☐ History & Physical	____________________	____________________
☐ Other ______________	____________________	____________________
____________________	____________________	____________________

Records are to be Disclosed From:

Name of Clinic/Doctor _________________________________ **Phone #**__________________________

Address ______________________________________ **Fax #**____________________________

City, State, Zip ______________________________

Records are to be Disclosed To: **Tanner Clinic**
Attn: Medical Records
2121 N 1700 W
Layton, UT 84041 (801)773-4840 Fax: (801) 525-8194

I hereby release the above-named facility or doctor(s) from all legal liability that may arise from the release of this information. I acknowledge that records to be released may include material that is protected by Federal Regulation 42 CFR, Part 2, including AIDS/AIDS Testing information, drug/alcohol information, and mental health information. My records are protected and cannot be disclosed without my written permission. I may make a request in writing at any time to this facility 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. My signature below authorizes the release of all requested information. Such authorization may be revoked in writing at any time. Disclosed information may be subject to redisclosure by the recipient.

____ ____
Signature of Patient Requesting Records (or representative if a minor) Date of Request

____ ____
Print Name of Patient or Representative & Relation to Patient Signature of Clinic Staff **Accepting** this Request