SOUTH VALLEY WOMEN'S HEALTH CARE, P.C.

GENERAL MEDICAL RECORDS RELEASE AND
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

This is to authorize the release of medical information regarding the above identified person.

❑ From ❑ To ❑ From ❑ To

Physician / Clinic: _____

Phone: _____ Fax: _____

Address: _____

City:_____

State: _____ Zip:_____

South Valley Women's Health Care, P.C.
3570 West 9000 South, Suite 210
West Jordan, UT 84088
Phone: 801-569-2626 Fax: 801-569-5333

INFORMATION TO BE RELEASED:

❑ All Records
❑ X-Ray / Radiology Records
❑ Date Range _____ to _____
❑ Laboratory / Pathology Records
❑ Chart Notes
❑ Other (be specific)

PURPOSE FOR TRANSFER OF RECORDS

❑ Permanent Transfer ❑ Referral ❑ Other _____

❑ I DO Specifically consent to the transmission of medical records VIA Facsimile (FAX) machine with the understanding that the *Confidentiality* at the receiving end cannot
❑ I DO NOT always be guaranteed.

I understand that after the custodian of records discloses my health information, it may no longer be protected by the federal HIPAA privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. By signing below, I represent, that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

South Valley Women's Health Care ✳ 3570 West 9000 South ✳ Suite 210 ✳ West Jordan, UT 84088
Telephone: 801-569-2626 ✳ Facsimile: 801-569-5333

SIGNATURE:

_____ _____ _____
Signature of Patient/Parent or Legal Guardian Relationship Date

_____
Print Name of Patient or Legal Guardian

This authorization expires six (6) months from date signed.