GRANGER MEDICAL CLINIC

Exceptional Care. One Patient at a Time.

GRANGER MEDICAL WEST VALLEY: 3725 West 4100 South, West Valley City, UT 84120
GRANGER MEDICAL WEST JORDAN: 3181 West 9000 South, West Jordan, UT 84088
GRANGER MEDICAL RIVERTON: 12391 South 4000 West, Riverton, UT 84065
GRANGER MEDICAL DRAPER: 11724 South State, Draper, UT 84020
MEDICAL RECORDS PHONE: 801-965-3471 ***FAX: 801-965-3537***
(All record releases are processed at the West Valley clinic.)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

***** THERE MAY BE A FEE FOR MEDICAL RECORDS*****

This authorization complies with all state and federal regulations and MUST BE COMPLETED IN ITS ENTIRETY to be valid. To ensure added security we DO NOT FAX medical records.

_____ _____/_____/_____
PATIENT NAME DATE OF BIRTH (MONTH/ DAY/ YEAR)

_____ _____
ADDRESS PHONE NUMBER

_____
CITY STATE, ZIP CODE

RELEASE MEDICAL RECORDS FROM:

_____
NAME OF CLINIC/ DOCTOR

_____
ADDRESS

_____
CITY STATE/ ZIP CODE

_____ _____
PHONE FAX#

RELEASE MEDICAL RECORDS TO:

_____
NAME OF COMPANY/ AGENCY/ FACILITY/ PERSON

_____
ADDRESS

_____
CITY STATE,/ZIP CODE

_____ _____
PHONE FAX#

INFORMATION TO BE RELEASED: HIPAA laws prohibit disclosure of other facility records including: hospital records, other clinic records, and medical records sent to us by other physicians on your behalf.

☐ LABS ☐ X-RAY ☐ PROGRESS NOTES ☐ ALL ☐ OTHER: _____
(SPECIFY)

_____ _____
DATE(S) OF TREATMENT(S) TO DISCLOSE PURPOSE OF DISCLOSURE (e.g. Continuing Care, School, Legal, Insurance, other)

☐ I consent to the release of information which may relate to: Alcohol/Drug Abuse, or contain: psychiatric information, HIV or Sexually Transmitted Disease testing results or AIDS information. INITIALS: _____

This authorization is valid for 1 year from the date of signing, and may be revoked at any time by sending a written request to the facility releasing your personal health information. Revocation of this authorization shall not affect Releases made prior to the revocation.
I understand that signing this release is voluntary, and that I need not sign this document in order to assume medical treatment by my provider. I further understand that the disclosure of this carries with it the potential for unauthorized re-disclosure and the information may no longer be protected by federal confidentially rules.

_____ _____/_____/_____
PATIENT SIGNATURE (If over 18) DATE: (MONTH/ DAY/ YEAR)

If patient is under 18, or unable to sign for themselves, please have parent, legal guardian or representative fill out the below section:

_____ _____ _____
SIGNATURE PRINTED NAME RELATIONSHIP TO PATIENT

PLEASE NOTE: A fee will be charged to the patient when they request their records be sent to a third party requestor. (e.g.: attorneys or insurance) However, no fee will be charged if sent to another continuing care provider. (e.g.: other physician, hospital or clinic)

*****PROOF OF ID REQUIRED TO RELEASE MEDICAL RECORDS***** ☐ ID COPIED AND ATTACHED TO THIS RELEASE FORM