Riverton & Zenith Family Health Center
1756 W Park Avenue
Riverton, UT 84065
Phone: 801-254-0309
Fax: 801-254-1012

Medical Record Release Authorization

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____ Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

Email Address_____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone_____

Fax_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone_____

Fax_____

C) For the purpose of:

____ Litigation
____Insurance
____Self/Personal Copy
____Transfer or Continuity of Care
____Disability
____Work Comp
____Other

Date Range _____to_____

☐ Physician Office Notes
☐ Radiology/XRays/MRI Reports
☐ Operative/Procedure Reports
☐ Cardiology/EKG Reports
☐ Other_____
☐ Minimum Necessary
☐ Immunizations
☐ Lab/Pathology

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality laws. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I understand the information in my medical record may include information relating to sexually transmitted diseases such as AIDS and HIV. It may also include information about the behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained. (Include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	☐ YES ☐ NO	Dates:_____
HIV Testing and results	☐ YES ☐ NO	Dates:_____
Mental Health	☐ YES ☐ NO	Dates:_____
Psychotherapy Records	☐ YES ☐ NO	Dates:_____

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
(Date) (Signature Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

PLEASE READ Fee Information: Riverton and Zenith Family Health Center contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical records state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of care or personal copy to patient, we may transfer a minimal portion of you records as a courtesy.