CopperView Medical Center
3556 West 9800 South Suite 101
South Jordan, Utah 84095
Phone: 801.567.9780 Fax: 801.567.9826
ATTN: Medical Records

CopperView Pediatrics

CopperView Adult Care

Authorization for CopperView Medical Center To Release Medical Information

Patient Name: _____

Date of Birth: _____

SSN: _____ Phone Number: _____

Release information to the facility/person below:

Name of person(s) or facility: _____

Address of the above: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

Email (optional): _____

Please release the following information:

___Complete Medical Record
___Most Recent Physical Exam Only
___Specific Date of Service: _____
___Lab Result/X-Ray Report Only
___Other (specify): _____

Reason for Release: _____

I understand that information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that I if revoke this authorization I must do so in writing and present my written revocation to the health information management department. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . **If I fail to specify an expiration date, event, or condition, this authorization will expire in twelve (12) months.** Furthermore, I understand that there may be a charge for the copying of records.

This information is disclosed from records whose confidentiality is protected by Federal Law. Regulations (42 CFR Part II) prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is not sufficient for this purpose.

I understand that, under HIPPA regulations, CopperView Medical Center cannot release any medical records that may have been released to CopperView by a previous provider.

Signature: _____ Relation to Patient: _____

Date: _____

PLEASE ALLOW TEN (10) TO FOURTEEN (14) BUSINESS DAYS TO PROCESS YOUR REQUEST.

For Office Use Only:
Form Received By: _____
ID: _____
Circle one of the following:
~Records given to pt.
~Records need to be processed
___Mailed ___Faxed ___Emailed