CANYON VIEW
Medical Group

Authorization to Use and Disclose Protected Health Information

Name _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Authorizes Canyon View Medical Group to:

☐ **Release medical information to**: ☐ **Obtain medical information from**:

Name _____ Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

The information released will be used for the following purposes: _____
(at the request of the individual, if left blank)

I specifically authorize the release of the following: Entire Record Yes __ No __ only the items listed below:

☐Visit/Encounter Notes ☐U/S MRI Report ☐Lab Report ☐EKG Report ☐X-Ray Report ☐Operative Report

Other – specify: _____

Dates of service: from _____ to _____ (If left blank, will only release 2 years)

This Authorization will expire on ____/____/____, or upon the following event:
If no date given, will expire 2 years from date signed

I acknowledge, and hereby consent to such, the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI and that it may no longer be protected by federal privacy regulation. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying CVMG in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by CVMG in reliance on this authorization before CVMG received my request for revocation or modification. I must sign my written request for revocation and send it to:

Canyon View Medical Group
Attn: Release of Information
325 West Center Street
Spanish Fork, UT 84660
Phone: 801-798-7301 Fax: 801-798-8513

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship or authority to sign: _____

Preferred Delivery Method:
☐ Fax to: _____
☐ Mail to Authorized Receiver above
☐ Pick up

There will be no charge to release medical records to another physician or health care supplier. However, there is a $0.50 per page copying charge plus tax, handling, and postage for any other individual or company. Other entities may have different rates as well.