



**Health Insurance Portability and Accountability Act
Release of Information Authorization**

Patient Name		Birth Date	
I hereby authorize the following to use and disclose my Protected Health Information (PHI) as described in detail below			
Authorized Sender (Doctor or facility sending records)	Name: Address: City/State/Zip: Phone: Fax:		
This authorization applies to the specific information listed below <i>(provide a specific and meaningful description including the time period of records)</i> :			
Authorized Receiver	Canyon View Medical Group Fax: 801-798-8513		
I authorize the following specified records of my PHI to be used and disclosed:			
<input type="checkbox"/> Office Notes <input type="checkbox"/> Lab Report(s) <input type="checkbox"/> Radiology Report(s) <input type="checkbox"/> Immunization Records <input type="checkbox"/> Complete Medical Record <input type="checkbox"/> Other: For Purpose(s) of _____			
This authorization will expire on ____ / ____ / ____, or upon the following event: <i>If no date given, will expire 2 years from date signed</i>			

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 receives 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

There will be no copying 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.