Murray Pediatrics Phone 801-262-2673 Fax: 801-269-9894

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:______________________________ Birth date:______________

Address:______________________________ Phone #______________

I authorize release of my medical records FROM:

____

Address: ____

Phone: ______________________________ Fax: ______________________

Please send my medical records TO:

____

Address ____

Phone: ______________________________ Fax: ______________________

Please release the following information:

___Immunizations ___All medical records ___Date of Service: from__________to__________

Release Information:

The purpose or need for this disclosure is:

___Further Medical care ___Attorney ___School ___Changing Physician

___Personal Use ___Insurance ___Other (Specify)__________________

Consent:

This information is intended by the above named recipient only. I have a right to receive a copy of this authorization. I may revoke this authorization at any time in writing.

Signature of Patient/Parent : ______________________________ Date: ______________