Families First Pediatrics
RELEASE OF MEDICAL INFORMATION CONSENT

I authorize (previous Doctor) _____

Of (Medical practice, address, & phone #) _____

to release my Medical Records to:

FAMILIES FIRST PEDIATRICS

1268 WEST SOUTH JORDAN PKWY, STE #201
SOUTH JORDAN, UT 84095
PHONE 801-254-9700
FAX 801-254-9755

13242 S. 5600 W.
HERRIMAN, UT 84096
PHONE 801-987-8541
FAX 801-987-8591

For the purpose of: _____

Name of Patient(s): _____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ _____
Signature of patient or legal representative Relationship to Patient

_____
Date Requested

If Matthew Cox, MD, Michael Johnson, MD, Dallen Ormond, NP, Zachary Zarbock, MD, Camille Goff, NP, or Tiffany Thomas, NP, are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire in 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Families First Pediatrics "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here:_____.
Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indication the effective date in the right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon request.
As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes.

We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose health information consistent with our notice.