FAMILIES FIRST PEDIATRICS | FAMILIES FIRST COUNSELING SERVICES | FAMILIES FIRST PEDIATRIC DENTISTRY AND ORTHODONTICS

Release of Medical Information Consent

Immunizations records may also be accessed through our Patient portal at no cost. Fill out this form in its ENTIRETY; if any section is incomplete, this from will not be processed.

Patient Name: DOB: Address: Phone #:

1._____
2._____
3._____
4._____

Release by (PLEASE CIRCLE ONE): Mail Email _____ Fax _____ Pickup Verbal

Information to be released:

____ Immunizations
____ Clinic/Office Notes (includes well and sick visits)
____ Radiology Reports
____ Labs
____ Full Medical Records (all the above, this will take up to 30 days to receive)
____ Mental Health Records (PSYCHOTHERPAY NOTES WILL ONLY BE RELEASED WITH A SUBPOENA)
____ Other_____

_____ Release to: Families First Pediatric
1320 W So Jordan Pkwy
So Jordan, UT 84095
P: (801) 254-9700 F: (801) 254-9755

_____ Release from: Families First Pediatric
1320 W So Jordan Pkwy
So Jordan, UT 84095
P: (801) 254-9700 F: (801) 254-9755

____ Release to: _____
Address: _____
City, State, Zip: _____
Fax: _____ Attn: _____
Email: _____

____ Release from: _____
Address: _____
City, State, Zip: _____
Fax: _____ Attn: _____
Email: _____

Terms of Authorization:

This authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here: _____ (if you are going on your mission list 18 months or 2 years, depending on length)

____ Initial here for personal use or indicate the purpose of the disclosure of your records here: _____ (i.e. Auto Claims, School, Legal, Switching Offices, etc.)

- I understand that the Families First Pediatrics, Families First Counseling and Families First Pediatric Dentistry and Orthodontics will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.
- I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):
  □ Mental and behavioral health □ Substance Use Disorder □ Genetic Testing
- I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Medical Records, 1320 W South Jordan Pkwy, South Jordan, UT 84095. Records may be released before you revoke your authorization and subject to re-disclosure by the recipient and may no longer be protected under federal privacy law.
- I understand that I may be charged for this information, and I agree to be financially responsible for the charge.
- I understand that HIPPA laws prohibit disclosure of other facility records including: hospital records, other clinic records, and medical records sent to us by other physicians on our behalf.

Parent's Signature: _____ **Date:** _____/_____/_____

Patient's Name (please print): _____ **DOB:** _____/_____/_____