

REQUEST FOR ACCESS TO PATIENT'S HEALTH INFORMATION

As our patient, you are entitled under Federal law to access your Personal Health Information (PHI). Your records are protected and cannot be disclosed without your permission unless otherwise authorized by law. **In compliance with state & federal regulations, there may be fees associated with this request. If charged, these fees will be calculated as follows: \$21.16 search fee + \$0.53 per page for the first 40 pages & \$0.32 per page for additional pages + actual cost of postage if mailed. Please allow up to 7 business days (not including weekends or holidays) to process your request after completing this form.** This request is valid for 30 days only – after which a new request must be completed. If you have any questions or concerns regarding your PHI, please contact our Medical Records Department at (801) 337-5800.

Indicate which one of the following methods you wish your records to be provided:

SECURE EMAIL MAIL PICKUP FAX *(may be limited depending upon amount of records)*

Requested By:

Chart No. _____

Name of Patient: _____

Phone No. _____

Address: _____

SSN: _____

City, State, Zip: _____

Date of Birth: _____

Records to Come From:

Name: _____

Phone No. _____

Address: _____

Fax # _____

City, State, Zip: _____

Date Records Required: _____

To be Released to:

Name: _____

Phone No. _____

Address: _____

Fax # _____

City, State, Zip: _____

Date Records Required: _____

Email Address (for secure email delivery): _____

Reason for Request: Changing Doctors/Practice Another Doctor Consultation For Own Use

Requested Records: Entire Chart Partial Chart - Date Range: _____ to _____

Labs: _____ Other: _____

Patient Signature

Patient Name (Print)

Witness

Date of Request