24 S 1100 E, Suite 301
Salt Lake City, Utah 84102
Phone: 801-521-2640
Fax: 801-363-6407

AUTHORIZAITON TO RELEASE INFORMATION

PATIENT NAME: ______________________ DATE OF BIRTH: ______________________

PATIENT CURRENT ADDRESS: ____

CURRENT PHONE NUMBER____

Please **CIRCLE** any that have been your provider:

Sharon Schriewer, MD Suzanne Holbrook, MD Jennifer Cox, MD Sandra Phillips, MD

Ginny Hiatt, FMP Paul Swensen, MD Louis Bourgenicht, MD

I authorize **SUNNYSIDE PEDIATRICS** to (please check ONE box below)

[ ] Release information to **[ ] Receive information from the following:**

PROVIDER/FACILITY: ____

ADDRESS: ____

PHONE: ______________________ FAX: ______________________________

Fee Schedule

Electronic Medical Record

provider to provider is professional curtesy- no charge (within 2 weeks)

Rush (within 48 hours)- $25

Personal Copy (within 2 weeks)- Call for price

Storage Medical Records

Vaccine Report (within 2 weeks)- $10

Complete Chart Report (within 2 weeks)- $25

Rush (within 48 hours)-$50

INFORMATION TO BE RELEASED:

- ☐ Complete health record
- ☐ Physical Exam
- ☐ Immunization records
- ☐ Lab/Radiology reports
- ☐ Consultation reports
- ☐ Other ______________
  ____

REASON FOR RECORD RELEASE:

- ☐ Change of insurance
- ☐ Moved
- ☐ Over 18 years old
- ☐ Referral to specialist
- ☐ Personal copy
- ☐ Unhappy with practice

______________________________ ______________________

Signature of Patient or Legal Guardian Date

______________________________ ______________________

Printed Name Relationship to Patient