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

AUTHORIZATION 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

1 authorize SUNNYSIDE PEDIATRICS to (please check ONE box below)

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

PROVIDER/FACILITY: ____

ADDRESS: ____

PHONE: ______________________________________ FAX: ________________________________

Fee Schedule

Electronic Medical Record

provider to provider is professional courtesy- 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