South Summit Pediatrics
Request for Release of Information

Please fax or mail records to
267 E Traverse Point Drive
Draper, UT 84095
Phone (801) 553-8000 Fax (801) 553-8301

PATIENT NAME LAST, FIRST, MI	DATE OF BIRTH (MO/DAY/YR)
PHONE NUMBER	SOCIAL SECURITY NUMBER

Consent for the provider indicated below to release information for the above patient:
Provider _____
Address _____
Phone _____ **Fax** _____

Records requested are to be released to:		
FACILITY NAME / PROVIDER **South Summit Pediatrics**		
ADDRESS **267 E Traverse Point Drive**		
CITY **Draper**	**STATE** **Utah**	**ZIP** **84020**
PHONE # **801-**	**FAX #** **801**	

Reason for Release: (Required)

Please send the following information:

___ Complete Record
___ Immunization Record
___ Specific Date of Service _____
___ X-ray reports
___ Most Recent Physical or Well Visit
___ Lab Results
___ Specific Office Notes _____
___ Other (specify) _____

I hereby authorize the releasing facility to release information as indicated. The releasing facility is hereby released from all legal liability that might arise from the release of the information requested. I understand that my records are protected and cannot be disclosed without my written permission, with the exception of information released pertaining to treatment, payment, or healthcare operations as specified by HIPAA or as required by law. I also understand that my consent for release is subject to my written revocation. This consent will remain in force for 30 days from the date signed in order to effectuate the purpose for which it was given. Furthermore, I understand that there may be a charge made for copying records.

Date:	Signature:	
Witness to Signature:	Relationship to Patient:	ID Checked by: