

Use this form if you would like medical records from another location sent to Alpine Pediatrics, P.C.



1912 West 930 North  
Pleasant Grove, Utah 84062  
Phone: (801) 492-1999  
Fax: (801) 492-1991

1307 N. Commerce Drive  
Suite. 120  
Saratoga Springs, Utah 84045  
Phone: (801) 922-9222  
Fax: (801) 922-9221

3231 North 1120 East  
Lehi, UT 84043  
Phone: (801) 768-2800  
Fax: (801) 766-5938

I request that the medical records marked below be released from:

Physician/Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

**Authority to Request Records (You must meet one of the following criteria):**

- 1) A parent may request records of his/her children.
  - Father
  - Mother
- 2) A patient who is of legal age may request his/her own records.
- 3) A person holding a power of attorney for a patient (documentation required).
  - Documentation copied and attached to this request.
- 4) A person or agency presenting a release of information signed by one of the above specifically authorizing release.
  - Documentation copied and attached to this request.
- 5) A court appointed legal guardian may request records (documentation required).
  - Documentation copied and attached to this request.

**Records Requested:**

Patient's Full Name	Birth Date	Immunization Records	Growth Chart	Medication List	Problem List	Other

**\* PLEASE ONLY SEND THE INFORMATION REQUESTED. ALL OTHER INFORMATION SENT WILL BE DESTROYED.**

Full Name of Patient's Father: \_\_\_\_\_

Full Name of Patient's Mother: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**THESE RECORDS ARE BEING USED FOR TREATMENT PURPOSES!**

Use this form if you would like medical records sent from Alpine Pediatrics to another location/individual.

## Individual Request for Access to Personal Health Information

<b>Authorization to release the health information of:</b>			
Patient Name: _____			
Current Address _____		City _____	State _____ Zip _____
Phone Number (    ) _____		Date of Birth    /    /	
<b>This Authorization is to release health information to:</b>			
Name: _____			
Address _____		City _____	State _____ Zip _____
Phone Number (    ) _____		Fax Number (    ) _____	
<b>Please indicate the means by which you wish to inspect or obtain a copy of the requested information:</b>			
<input type="checkbox"/> Review the records on-site. <input type="checkbox"/> Pick up copies of requested records at office. <input type="checkbox"/> Other: _____	<input type="checkbox"/> Fax copies of records to: _____ _____ <input type="checkbox"/> Mail copies of records to: _____ _____		
<b>Reason for Request:</b> _____			
<b>Dates of service:</b> _____			
<b>Please indicate specifically the information to which you are requesting access:</b>			
<input type="checkbox"/> Offices Notes <input type="checkbox"/> Lab report(s) <input type="checkbox"/> Other records as specified: _____ <input type="checkbox"/> Immunization Records _____			
<p>As provided in the Health Insurance Portability and Accountability Act, you have a right of access to inspect and obtain a copy of your health information contained in a designated record set. This right does not apply to:</p> <ol style="list-style-type: none"> <li>1. Psychotherapy notes;</li> <li>2. Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and</li> <li>3. Protected health information that is: (a) subject to the Clinical Laboratory Improvements Amendments of 1988, 42 USC 263a, to the extent the provision of access you would be prohibited by law; or (b) exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3 (a)(2).</li> </ol>			
<p>Alpine Pediatrics, P.C., will act on this request within 30 days of the date listed above or, within 60 days if the requested information is not maintained or accessible to Alpine Pediatrics, P.C., on-site. Such action will either inform you of the acceptance of the request and provide you with the requested access; or provide a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed.</p> <p>If the requested information is contained in more than one designated record set or at more than one location, and access is granted, Alpine Pediatrics, P.C., needs only to provide you with access to information contained on one of the designated record sets.</p> <p>If Alpine Pediatrics, P.C., cannot readily produce the information in the form or format you have requested such information will be made available to you in a readable hard copy form or other form or format agreed to.</p> <p>Alpine Pediatrics, P.C., does not charge for the first ten pages of copies it makes of your personal health information. Alpine Pediatrics, P.C., does charge \$0.10 per copied page of your personal health information after the first ten pages. Payment must be received before records will be released.</p>			

**Request will remain in effect for six months from original signing.**

Signature of Patient or Legal Representative	Date
Printed Name of Person Signing Above	Relationship to patient or representative's authority to act for patient, if applicable