CEDAR RIDGE
FAMILY MEDICINE

110 W 1325 N, Suite 200, Cedar City, UT 84721
1760 N Main St, Suite 103, Cedar City, UT 84721
(435) 586-7676 · (435) 586-2290

Physician Request for Medical Records

(RECORDS FROM ANOTHER OFFICE - 315.5)

_____
Name of Physician or Facility to which this request is made

_____

_____
Address

_____ _____
Telephone number Fax number

_____
Name of Provider you see at Cedar Ridge Family Medicine

Patient Authorization for Release of Medical Records and Information

Patient Information:

Name: _____ **Date of Birth:** _____/_____/_____ **Social Security Number:** _____-____-_____
(to verify accuracy)

Information to be disclosed:	**Authorization Expires:**
[ ] Entire medical record including, without limitation, personal health information and other records pertaining to treatment **[ ]Other:**_____ _____	**[ ] 365 days** from the date of this authorization **[ ] 90 days** from the date of this authorization **[ ] Other:**_____
[ ] I understand that I have the right to revoke this authorization in writing submitted at any time to Cedar Ridge Family Medicine, and that the revocation will be effective except to the extent that action has been taken in reliance on the previous Authorization.	**[ ] I understand** that signing this release is voluntary and that I may decline to sign this Authorization. I understand that any Provider of Cedar Ridge Family Medicine may refuse to provide me with research-related treatment if I do not authorize disclosure of my PHI.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS FORM.

_____ _____
Signature of person requesting records **Date**

_____ _____
Printed name of person requesting records **Relationship to Patient**

_____
CRFM Witness Signature

Please fax records to (435) 586-2290
Or mail records to the following address in an envelope labeled "Confidential"

Cedar Ridge Family Medicine
Attention: Medical Records
110 West 1325 North #200
Cedar City, Utah 84721