HIPAA Authorization Request for PHI

557 West 2600 South, Bountiful, UT 84010
Phone (801) 298-9155 - Fax (801) 298-9156

Ralph D Wade DO
Sandra B Waite CFNP
Brittaney Cahoon CFNP
Debra Wing CFNP
Allison Hanna DO
Sean Webster PAC
MarDiene Jeffs PAC
David Badham PA
Allen Freestone MD
Niesha Nelson DNP
Lindsay Martinez APRN

Patient's Name:_____

Date of Birth: _____/_____/_____ Phone: (_____) _____ - _____

Records From:_____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

SEND Record To:_____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Address:_____City:_____State:_____ Zip:_____

Please send us the following:

- ☐ 2 years of Lab reports
- ☐ 2 years of Visit notes
- ☐ All Radiology reports
- ☐ All Immunizations
- ☐ Last Mammogram
- ☐ Last Bone density
- ☐ Last 3 pap smears
- ☐ Last Colonoscopy
- ☐ Entire Health Record

☐ Other:_____

Would you like your electronic records in: ☐ Mail ☐ Fax ☐ Disc

I hereby authorize the above named clinics and physicians to release my health information for my treatment. This authorization is valid for 90 days. I have the right to revoke this authorization at any time by contacting Wade Family Medicine. I understand that the information disclosed may be subject to re-disclosure.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
*Legal Representative's Printed Name	Legal Representative's Signature	Date