FAMILIES FIRST PEDIATRICS | FAMILIES FIRST COUNSELING SERVICES | FAMILIES FIRST PEDIATRIC DENTISTRY AND ORTHODONTICS

## Release of Medical Information Consent

*Immunizations records may also be accessed through our Patient portal at no cost. Fill out this form in its ENTIRETY; if any section is incomplete, this from will not be processed.* ***Please submit this form via E-Mail recept@ffpeds.com, fax (801)254-9755, or by mail.***

Patient Name: DOB: Address: Phone #:

1._____
2._____
3._____
4._____

Release by (PLEASE CIRCLE ONE): Mail Email Fax Pickup

Information to be released:

____ Immunizations
____ Clinic/Office Notes (includes well and sick visits)
____ Radiology Reports
____ Labs
____ Full Medical Records (all the above, this will take up to 30 days to receive)
____ Mental Health Records (PSYCHOTHERPAY NOTES WILL ONLY BE RELEASED WITH A SUBPOENA)
____ Other_____

_____ Release to: Families First Pediatric
1320 W So Jordan Pkwy
So Jordan, UT 84095
P: (801) 254-9700 F: (801) 254-9755

_____ Release From: Families First Pediatric
1320 W So Jordan Pkwy
So Jordan, UT 84095
P: (801) 254-9700 F: (801) 254-9755

____ Release to: _____
Address: _____
City, State, Zip: _____
Fax: _____ Attn: _____
Email: _____

____ Release from: _____
Address: _____
City, State, Zip: _____
Fax: _____ Attn: _____
Email: _____

**Terms of Authorization:**

____ Initial here for one time disclosure. Otherwise, this authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here: _____ (if you are going on your mission list 18 months or 2 years, depending on length)

____ Initial here for personal use or indicate the purpose of the disclosure of your records here: _____ (i.e. Auto Claims, School, Legal, Switching Offices, etc.)

- I understand that the Families First Pediatrics, Families First Counseling and Families First Pediatric Dentistry and Orthodontics will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.
- I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):
  □ Mental and behavioral health □ Substance Use Disorder □ Genetic Testing
- I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Medical Records, 1320 W South Jordan Pkwy, South Jordan, UT 84095. Records may be released before you revoke your authorization and subject to re-disclosure by the recipient and may no longer be protected under federal privacy law.
- I understand that I may be charged for this information, and I agree to be financially responsible for the charge.
- I understand that HIPPA laws prohibit disclosure of other facility records including: hospital records, other clinic records, and medical records sent to us by other physicians on our behalf.

**Patient's Signature:** _____ **Date:** _____/_____/_____

**Patient's Name (please print):** _____ **DOB:** _____/_____/_____