Old Farm
Obstetrics and Gynecology, L.L.C.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization form has been specifically designed to comply with all state and federal regulations pertaining to the confidentiality of health information. In order for this form to be considered valid it must be completed in its entirety.

PATIENT INFORMATION

FULL NAME:		DATE OF BIRTH:	
HOME ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:		

SEND RECORDS:
[ ] TO [ ] FROM

Dr Spencer P. Barney Dr. Bryant J. Brown Dr Erica A. Faircloth

Dr Alan T. Rappleye Dr James T. Roth

Old Farm Obstetrics and Gynecology
3970 South 700 East, Suite 14
Salt Lake City, Utah 84107
Telephone (801)261-3605 Fax (801)262-9142

SEND RECORDS:
[ ] TO [ ] FROM

PHYSICIAN/CLINIC:			
ADDRESS:	CITY:	STATE:	ZIP:
PHONE:	FAX:		

INFORMATION REQUESTED

[ ] ENTIRE RECORDS [ ] RECORDS FOR DATES_____THROUGH_____

[ ] OTHER (BE SPECIFIC)_____

_____

PURPOSE OF DISCLOSURE_____

_____

This Authorization is valid for 90 days from the date set forth below opposite my signature and may be revoked at any time in written prior to the expiration of such 90 day period. Revocation of this authorization shall not affect releases made prior to the revocation. I understand that authorizing the disclosure of my protected health information is voluntary and that I need not sign this authorization in order to assure medical treatment. I further understand that the disclosure of this information carries with it the potential for unauthorized redisclosure and the information may no longer be protected by federal confidentiality rules. I certify that I have the authority to approve this requested release of information and to sign the authorization.

SIGNATURE

SIGNATURE OF PATIENT/ LEGAL GAURDIAN:	DATE:
PRINT NAME OF PATIENT/LEGAL GAURDIAN:	RELATIONSHIP TO PATIENT: