GRANDVIEW
FAMILY MEDICINE
My Health, My Family, My Clinic
1900 N. State Street • Provo, Utah 84604 • (801) 373-2001

HIPAA Disclosure Authorization Form Release of Private Health Information

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I, _____, hereby authorize Grandview Family Medicine to
(Please Print)
disclose protected health information about me as described below.

1. The following person or class of persons may receive the disclosure of protected health information.

   Name(s): _____ Relationship: _____

   _____ _____

   _____ _____

   _____ _____

2. Specific information to be disclosed is: (*if blank, complete record will be disclosed*)

   All Records_____ Vaccines_____ Office Notes_____ Lab Results_____ Rx Pick Up_____

3. I understand that if the person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
4. I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Grandview Family Medicine. However, if I do revoke this authorization my revocation will not affect any prior actions taken in reliance on my authorization.
5. This authorization will expire on _____/_____/_____ (MM/DD/YY); or upon the following event:_____.

I certify that I have read, signed and received a copy of this authorization.

_____ _____
Signature of Patient or Patient's Representative Patient's Date of Birth

_____
Date

_____ _____
Relationship of Representative to Patient Representative's Date of Birth