

JORDAN LANDING CLINIC, LLC
7478 Campus View Drive, Ste 100
West Jordan, Utah 84084
Phone: 280-7774, Fax: 748-2790

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name _____ DOB: _____
Address: _____
Phone: _____

Please release records for the above identified person:

Clinic to release records:	Release to:
Facility _____	Jordan Landing Clinic, LLC
Address _____	7478 Campus View Dr, Ste 100
_____	West Jordan, Utah 84084
Phone # _____	Phone (801) 280-7774
Fax # _____	Fax (801) 748-2790

COPIES OF RECORDS REQUESTED/CHECK ALL THAT APPLY

History & Physical _____	Pathology reports _____
Lab results _____	X-Ray reports _____
Progress notes _____	Other _____

It is the policy of Jordan Landing Clinic to require current specific authorizations to release the types of information listed below. As a result, if such information is contained in the patient's records, which information has not been released by the patient previously, can be released at this time.

Mental Health Information _____ AIDS/HIV Testing _____ Drug/Alcohol Information _____
I understand that my records are protected and cannot be disclosed without my written permission.

SIGNATURE _____ **DATE** _____

WITNESS _____ **DATE** _____

If signed by someone else other than the patient, relationship and legal grounds for representatives authority to request records. _____ .

PLEASE NOTE: A fee will be charged to the patient when they request their records to be sent to other third party requestors. (e.g: other physicians, hospital or clinic).