UTAH VALLEY
OBSTETRICS & GYNECOLOGY

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AUTHORIZATION TO RELEASE INFORMATION

Patient's Full Name (inc. Maiden Name): _____ Date of Birth: _____

Address: _____ Phone: _____

This is to authorize medical information regarding the above-identified person to be released

From or To: (**circle one**)
Utah Valley Obstetrics & Gynecology
1055 North 300 West Suite 108, Provo, UT. 84604
(801) 357-7377 Fax (801) 357-7378

From or To: (**circle one**)
Provider/Facility Name: _____

Address: _____

Phone and Fax Number: _____

Check records to be released:

( )	Labs	( )	Imaging	( )	All
( )	Office Notes	( )	Procedures Performed		

I hereby consent to release and disclose the above information obtained in the course of my diagnosis and treatment to the intended parties described above.

Signature: _____ Date: _____

PLEASE NOTE: A fee will be charged to the patient when requesting records to be released to themselves or any third party requestors (attorneys, insurance, or other physician). However, no fee will be charged if the patient is referred to another physician from our office. We also require forty-eight hours to process the request and no medical records will be released until the appropriate fee has been collected.