MOUNTAINSTAR
Lone Peak
Primary Care
affiliated with St. Mark's Hospital

Authorization to Release Patient Health Information

Lone Peak Primary Care
74 E. Kimballs Lane ● Suite 260 ● Draper, Utah 84020
Phone: 801.545-.8480 ● Fax: 801.545.8495

Patient Legal Name: _____ Date of Birth: _____

Phone Number: (____) _____ Social Security Number: _____

Date of Request: _____ Date Needed: _____

Release information *from*:	**Release information *to*:**
_____ Organization/Person Name _____ Street Address _____ City, State, Zip _____ Telephone _____ Fax Number	□ Dr. Anne Dubosky □ Dr. Nichole DeLaPlante □ Erin Coppin, PA-C 74 E. Kimballs Lane, Suite 260 Draper, UT 84020 Phone: 801.545.8480 Fax: 801.545.8495

TYPE OF RECORDS REQUESTED (Charges for copies of records may be associated with your request)

Sensitive records may require patient authorization.
Please initial the appropriate records requested.

☐ Entire Clinical Record
☐ Laboratory/Diagnostic tests
☐ X-ray Films
☐ Other_____

_____ Drug and/or Alcohol Abuse
_____ Mental Health (may include Pain Management or Psychiatry records)
_____ Sexually Transmitted Diseases (including AIDS/HIV)

Purpose or need for records: ☐ Continuing care ☐ Copies for my own use ☐ Other_____

Patient Rights:
I understand that I have the right to revoke this authorization, *in writing*, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, I can write a letter to the person or entity holding the authorization, providing details of the date and content of the original authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may not longer be protected by federal or state law.
I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization.

_____ _____ _____
Date Signature of Patient or Representative Relationship to Patient