Authorization to Release/Obtain Patient Information

This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. For authorization to disclose alcohol or drug abuse information see 42 CFR and AR 600-85. (Pursuant to the Privacy Act of 1974, Public Law 93-579)

This authorizes Color Country Pediatrics and its affiliates to release/obtain information as described below.

Physician/ Facility Authorized to release/obtain patient information:

(who we are requesting records from or sending records to)

Physician/Facility Name:	
Address:	
Phone:	Fax:

Patient Information:

- Patient Name:_____
- Date of Birth: _____
- Address: _____
- City, State and Zip: _____
- Telephone: _____

Records Being Requested:

- ☐ Full medical record
- ☐ Immunization Record
- ☐ Billing Information
- ☐ Dates: from _____ to _____
- ☐ Other: _____

Use of Medical Information:

- ☐ Further Medical Care
- ☐ Disability Determination
- ☐ Insurance Claims
- ☐ Attorney
- ☐ Personal
- ☐ Other: _____

★ **Release Authorization:**

I hereby request and authorize the named physician/facility to release the medical information described above to the named individual indicated.

Signature of Patient/Parent/Guardian: _____ *Date:* _____

Relationship to Patient: _____

Information Destination:

Color Country Pediatrics
55 E Canyon Commercial Ave
Cedar City, UT 84721
Phone: (435) 865-0218
*Fax: (435) 865-0228
PLEASE DO NOT SEND ON A DISC!

Brian N. Burrows, M.D., FAAP
Craig S. Nielsen, D.O., FAAP
Gia D. Miller, M.D., FAAP
Taran E. Hansen, PA-C