Physician Group
OF UTAH, INC.

MEDICAL AND FINANCIAL INFORMATION AUTHORIZATION AND RELEASE

The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) of 1996 was created with the sole purpose and goal of protecting patients' medical records and financial information. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I authorize the staff of Physician Group of Utah, Inc. to release any FINANCIAL INFORMATION to the following people:

SPOUSE: _____

PARTNER: _____

PARENT/GUARDIAN: _____

OTHER: _____

I authorize the staff of Physician Group of Utah, Inc. to release any MEDICAL INFORMATION to the following people:

SPOUSE: _____

PARTNER: _____

PARENT/GUARDIAN: _____

OTHER: _____

I authorize the staff of Physician Group of Utah Inc. to leave laboratory or radiology tests results on my voice mail at the following telephone numbers:

Home Number: _____ Cellular Number: _____

Other: _____

_____
Medical Record Number

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient/Guardian/Personal Representative Date