



# Cherry Tree Family Practice

155 North 400 West, B6  
Orem, UT 84057  
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UD 403

## Authorization to Release Information FROM Cherry Tree Family Practice

### Please Read this Authorization Carefully.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected. As our patient we want you to know that we respect the privacy of your personal medical records and other information. We will take every reasonable precaution to secure and protect your privacy.

### Your Understanding in Regards to this Authorization.

- You understand that ~ You do not have to sign this authorization
- ~ If the organization or person authorized to receive this information is not a health care plan or provider, that your information may no longer be protected by federal policy regulations.
  - ~ You can revoke this authorization at any time by sending written notice of revocation to the Privacy Officer of Cherry Tree Family Practice.
  - ~ Your revocation is not in force until received by the Privacy Officer and cannot have any affect on actions already taken in reliance on an authorization given prior to the revocation.
  - ~ Compensation may be assessed for the fulfillment of this Request to Release Information.

**By signing below, I authorize:** Cherry Tree Family Practice, 155 North 400 West, Suite B6, Orem, UT 84057

### To Release the following information:

- Entire Medical Record
- Medical records specifically related to the following treatments, dates of treatment or conditions.
- \_\_\_\_\_

- Other specific information as listed below.
- \_\_\_\_\_
- \_\_\_\_\_

### For the following Purpose(s):

\_\_\_\_\_

\_\_\_\_\_

### Information to be released to:

\_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### Method of Release of Information:

- Mail to address at left
- Please fax to (#): \_\_\_\_\_
- (By choosing Fax option, the authorizer assumes all risk of information being used or disclosed to unauthorized persons or entities)*
- To Be Picked Up
- By Whom: \_\_\_\_\_
- Signature of Person Picking Up Records: \_\_\_\_\_
- Date Picked Up: \_\_\_\_/\_\_\_\_/\_\_\_\_

This Authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_. If no date is specified, expiry is 90 days from the signature date.  
DD MM YY

**Patient Name (Print):** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Legal Guardian(Print):** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Provider Authorization to Release \_\_\_\_\_ Fee Assessed \$ \_\_\_\_\_ Collected \_\_\_\_\_

Date Records Sent: \_\_\_\_/\_\_\_\_/\_\_\_\_ By Whom (Init): \_\_\_\_\_ Paid By: Check \_\_\_\_\_ Cash \_\_\_\_\_  
MC VISA DISCOVER AMEX