

Olympus Clinic

4624 Holladay Blvd. SLC, Utah 84117

Phone: (801) 277-2682 Fax: (801) 277-2980

Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:

Patient Name: _____

Address: _____
Street City State Zip

Phone Number: (____) _____ Date of Birth: _____

This authorization is to release the protected health information **from:**

Name: _____

Address: _____
Street City State Zip

Phone Number: (____) _____ Fax Number: (____) _____

This authorization is to release the protected health information **to:**

Name: _____

Address: _____
Street City State Zip

Phone Number: (____) _____ Fax Number: (____) _____

Release the following information:

Dates of Service (please check one)

All Dates

_____ to _____
(Beginning Date) (Ending Date)

Lab Results **Only** Dates: _____ to _____
(Beginning Date) (Ending Date)

Vaccine Records **Only**

I understand that I am responsible for notifying Olympus Clinic of any changes in the release of any diagnostic test or procedure results.

Patient Name: _____ Date: _____

Signature: _____ Relationship: _____