UTAH NATURAL MEDICINE
242 S. 400 East, Suite A; Salt Lake City, UT 84111 • Tel. 801-363-UTAH (8824)

PATIENT AUTHORIZATION OF
MEDICAL RECORDS REQUISITION

Name of Patient: _____ Date of Authorization/Request: ____/___/_____

Date of Birth: ___/___/_____ Patient Social Security #: _____-___-_____

Phone #: (___)____-_____ Patient Address: _____

_____

I, _____, authorize Utah Natural Medicine to receive patient's medical records from:

(Medical Facility) _____

Dr. _____

Address:_____

_____

Phone: ( ) _____-_____

Fax: ( ) _____-_____

Please release records for the period beginning ____/____/_____ to ____/____/_____
Please Release/Disclose the following information: (Circle to indicate selection)

History & Physical	Treatment Plans
Educational Reports	Consultation Reports
Radiology and Lab Reports	Discharge Summary
Outpatient Clinical Records	ALL Available Records

Other: (please list):_____

Please Fax/Send my records to Utah Natural Medicine at:

Address: 242 S. 400 East, Suite A
Salt Lake City, UT 84111

Fax: (801) 363-8821

I understand that I may revoke this authorization at any time by sending written notice to records holding facility listed above.

_____ _____
Patient's Name (Print) Patient's Signature