Mountain West Pediatrics
Jim J. Gould, MD PC
2356 N 400 E Suite 202
Tooele, UT 84074
435-843-8380 fax 435-843-8382
RELEASE OF MEDICAL INFORMATION CONSENT

Authorization to release the health information of:

Patient Name: _____

Current Address: _____ City_____ State _____ Zip _____

Phone Number ( ) _____ Date of Birth _____

Who are we releasing information to:

Name: _____

Address: _____ City_____ State _____ Zip _____

Phone Number ( ) _____ Fax Number ( ) _____

Reason for Request: _____

Please specifically indicate the information requested: please check

- ☐ **All Medical records**
- ☐ **Office Notes**
- ☐ **Immunization records**
- ☐ **labs**

If Dr. Gould or his mid-level providers is requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed; and
- You may refuse to sign this authorization

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire in 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

The information released has a potential for information to be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Jim J. Gould, MD P.C. dba Mountain West Pediatrics, does not charge for the first ten pages of copies it makes of your personal health information but does charge $0.10 per copied page after that.

_____ _____ _____
Signature of patient or legal representative Relationship to Patient Date Signed

Please fax or mail the requested health information to the address listed at the top of the page