



**MEDALLUS**

**M E D I C A L**

*Get well. Stay healthy for less.*

P. O. Box 1000 Draper, UT 84020 • Phone (801) 260-1919 • Fax (801) 260-1441

**MEDICAL RECORDS RELEASE AUTHORIZATION**

**Patient Information**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN : \_\_\_\_\_

**Persons Authorized to Use or Disclose information**

\_\_\_\_\_  
Name of person or organization

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Persons to Whom Information May Be Disclosed**

\_\_\_\_\_  
Name of person or organization

Fax Records: \_\_\_\_\_

Email Records: \_\_\_\_\_

Mail Records: \_\_\_\_\_

**Purpose of Disclosure**

\_\_\_\_\_  
[“At the request of the individual” when individual initiates authorization and does not provide purpose]

**Information to be Used or Disclosed (check all that apply)**

**Date(s) of Service (do not leave blank)**

- Physician's progress notes
- Consultation reports and correspondence from other facilities
- Laboratory test results
- X-ray radiologist reading
- X-ray films
- Billing account history
- Other: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Expiration Date of Authorization**

This authorization is effective for six months unless revoked or terminated by the patient or the patient's personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Medallus Medical, P.O. Box 1000 Draper, UT 84020.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guarantor ID Verified By