Pediatric Care

Kenneth A. Zollo, M.D.
Joshua D. Fuller, M.D.
Kent Blad, F.N.P.
Michelle Smith, F.N.P.
Canessa Craigo Leeflang, F.N.P.

1675 N. Freedom Blvd.
Building #3
Provo, UT 84604
Phone: 801-377-8000
Fax: 801-377-8001

Authorization to Release Health Information for:

Patient Name:	Date of Birth:
______________________________	____________
______________________________	____________
______________________________	____________
______________________________	____________
______________________________	____________

Release to:

Name: ______________________________
Address: ______________________________
City: ______________ State: ______ Zip: ____________
Phone: ______________ Fax: ______________

Release from:

Name: ______________________________
Address: ______________________________
City: ______________ State: ______ Zip: ____________
Phone: ______________ Fax: ______________

Dates of Treatment: ______________________________

Purpose of Release:

- ☐ Changing Providers
- ☐ Relocating
- ☐ Insurance
- ☐ Other: ____________

Release of:

- ☐ Immunizations Only
- ☐ Complete Medical Record
- ☐ Other: ____________

Medical records are required to be kept for 7 years from the last date of visit. Due to the need for records beyond 7 years, Pediatric Care keeps records for 18 years from the last date of visit as a courtesy to our patients. There may be a charge for copying and mailing of medical records depending on location and year of the record. Payment is required before record will be released. The charges are as follows: **Immunizations Only** – Records onsite and/or up to 7 years old: free. Records beyond 7 years old: $5.00. **Complete Medical Record** – Records onsite: $15.00. Records offsite: $25.00.

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is making the disclosure has already taken action in reliance upon it.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation, this authorization shall remain in full force and effect and shall not otherwise expire. Date this authorization expires: ____________________

I hereby consent to and authorize the release of this health information.

Signature of Patient or Guardian:

______________________________ Date: ______________