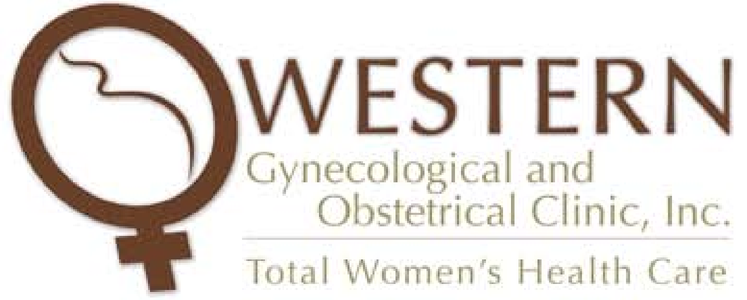
Request for Records Release



Name: ____________________

Date of Birth: ____________________

Social Security Number: ____________________

Address: ____________________

City, State, Zip: ____________________

Home Phone: ____________________

Work Phone: ____________________

Fax Number: ____________________

I HEREBY AUTHORIZE (Where records are being requested from):

Name: ____________________

Address: ____________________

Phone Number: ____________________

Fax Number: ____________________

TO RELEASE MY RECORDS TO (Where records need to be sent):

Address: ____________________

Phone Number: ____________________

Fax Number: ____________________

Date Records are needed by: ____________________

THIS RELEASE IS VALID FOR 90 DAYS ONLY. Most requests will be processed in 5-7 business days. I understand all copying fees will be billed to my account and I am responsible for payment.

____
Patient's Signature

____
Date

PLEASE CHECK ONE

- ☐ Transferring Care
- ☐ Last five years
- ☐ Records concerning: ____________________
- ☐ Records from date(s) of service: ____________________
- ☐ Labs (For dates of service): ____________________
- ☐ Other: ____________________

OFFICE USE:

Received By: ____________________

Date Mailed: ____________________

Date Faxed: ____________________

Date Pl. Picked Up: ____________________

Sent By: ____________________

Please fill out this form completely and sign it. You can either fax it back to us at 801-285-4801 or email it to records@westerngynob.com. There will be no charge for copies that are being sent to another doctor, otherwise there will be a $25 handling fee. Please allow 5 to 7 working days for your records to be processed. If you have any questions, please call us at 801-285-4800.

12600 South 3723 West, Suite 350, Riverton, Utah 84065 | ph 801-285-4800 | fx 801-285-4801 | www.westerngynob.com