Authorization for Release of Protected Health Information

I request that the medical records marked below be released from:

**** ALL INFO MUST BE FILLED IN TO BE VALID ****

Physician/Hospital: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip Code: _____

To: Joseph M. Johnson M.D.
1675 N 200 W Suite 9C
Provo, UT 84604
Phone: 801-377-4800
Fax: 801-377-4041

Parent/Guardian Name: _____
DOB: _____ Relationship: _____

Authority to Request Records:

- ☐ Patient is of legal age requesting their own records
- ☐ Parent is requesting their child's records
- ☐ A court appointed legal guardian is requesting records (documentation may be required)
- ☐ Other: _____

Please specify which records you need for each child listed.

Patient's Full Name:	DOB:	All Records	Immunizations	Office Notes	Hospital Records	Lab	X-Ray	Other

Signature: _____ Date: _____