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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/facility/entity listed below.

Patient Name: _____ Date: _____

The information you may release subject to this signed release form is as follows:

Complete Records History & Physical Lab Reports
 Radiology Reports Pathology Reports Operative Reports
 Other (please specify below)

Release my protected health information to the following physician/person/facility/entity:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The purpose/reason for this release of information is as follows:

I understand that **Dr. Jon Bishop, M.D.** will provide this information.

Patient Name

Signature of Patient or personal representative

Patient date of birth and SSN

Printed name of patient or representative

Date

Description of Personal representative's authority