CENTER FOR HEALTH & COUNSELING
Salt Lake Community College

Phone: 801-957-4268 Fax: 801-957-4341

CONSENT TO RELEASE MEDICAL INFORMATION

(Valid for 90 days following dated signature)

Name of Patient _____ Date of Birth ____ / ____ / ____

Student ID Number _____ Approximate dates of service _____

Information to be released: (**Only services performed at the Student Health Center will be released**)

_____ Immunization records _____ Clinical Records

_____ Lab reports _____ Electrocardiogram

_____ X-ray reports _____ Allergy records

_____ Other (specify) _____

I request the above information to be released FROM:

Name: _____

Fax Number:_____

Phone Number:_____

And released TO:

Name: _____

Fax Number:_____ Phone Number:_____

Email: _____

RELEASE OF INFORMATION FROM THE STUDENT HEALTH CLINIC MUST COMPLY WITH THE GOVERNMENT RECORDS ACCESS AND MANAGEMENT ACT (GRAMA)(Reference Material). ACCESS TO THESE RECORDS IS LIMITED. BEFORE WE RELEASE THE RECORD WE ARE REQUIRED BY *GRAMA* TO OBTAIN EVIDENCE OF THE REQUESTER'S IDENTITY. PLEASE COME INTO OUR OFFICE AND PRESENT IDENTIFICATION OR COMPLETE THE AFFIDAVIT BELOW AND RETURN IT TO US. ALL REQUESTS FOR INDIVIDUALS RECEIVED BY MAIL MUST BE NOTARIZED.

AFFIDAVIT

I have read the above statement and understand that access to the records I have requested is restricted and that there are criminal penalties for obtaining a government record by false pretenses. I am entitled to authorize the release of this I formation because:

_____ I am the subject of the record

_____ I am authorized to have access by the subject of the record and I have attached the required documentation.

Name _____ Relationship if patient is minor: _____

Signature: _____Telephone:_____ Date: _____

Witness/Notary: _____Date: _____