

*Leonard J. Swinyer, M.D., P.C.*  
*Leonard J. Swinyer, M.D., Laurie Ellis, N.P., Michael R. Swinyer, P.A.-C.*  
*3920 South 1100 East #310*  
*Salt Lake City, UT 84124*

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

ID# \_\_\_\_\_

(for office use only)

1. I authorize the following individual or organization to release my protected health information:

\_\_\_\_\_ Physician/office

\_\_\_\_\_ Address

\_\_\_\_\_ Phone/Fax

2. The following information may be released (MUST BE SPECIFIC): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. This information may be released to:

\_\_\_\_\_ Name

\_\_\_\_\_ Address

\_\_\_\_\_ Phone/fax

4. This information is being requested for the following purpose(s):

\_\_\_\_\_  
\_\_\_\_\_

5. This authorization will expire on \_\_\_/\_\_\_/\_\_\_ (DD/MM/YR); or as described below:

\_\_\_\_\_  
\_\_\_\_\_

PLEASE SEE OTHER SIDE

I hereby authorize the release of my protected health information as described and understand and acknowledge the following:

- I may refuse to sign this authorization, however, I do understand that my records will not be released if I do not sign it.
- My treatment or billing for treatment by Leonard J. Swinyer, M.D., P.C. will not be affected by my decision to sign or not sign this authorization.
- If the organization or person authorized to receive this information is not required to comply with federal privacy regulations (such as an employer or a school), the released information could be re-disclosed by them and would no longer be protected.
- I may inspect or copy the protected health information requested in this authorization as permitted by federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Dr. Swinyer's records custodian. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
- If I have any questions about this authorization, I may contact the records custodian at 801-266-8841, who will provide me with more information about this authorization or about our privacy practices.

**I certify that I have read, signed and received a copy of this authorization.**

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Patient Name (Please print)

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Signature of Patient (or Patient's representative)

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Date

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Relationship of Patient representative to Patient