CHAD C. LUNT, MD PC
TRACY D. KVARFORDT, MD PC
LISA A. BORUNDA, FNP-BC
KATIE A. GUBLER, CNM
DAWN H. BRANNON, FNP-C
ELIZABETH A. DEMILLE, PA-C

Obstetrics and Gynecology

515 South 300 East, Suite 205
St. George, UT 84770
Phone: (435) 674-0999
Toll Free: (877) 432-0168
Fax: (435) 674-0960
www.luntandkvarfordt.com

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
_____
_____

I hereby authorize you to release medical records on:

Name: _____ DOB: _____
Address: _____
_____

Please mail records to: **Lunt & Kvarfordt, LLC**
515 S. 300 E. #205
St. George, UT 84770

Or fax to: **(435) 674-0960**

In addition to the general authorization to release records to the person(s) or entities listed above, I authorize the release of the records described as the following:

___ Yes ___No COMMUNICABLE DISEASE-RELATED INFORMATION, INCLUDING RECORDS OF TESTING, DIAGNOSIS, OR TREATMENT OF HIV, HIV-RELATED ILLNESS, AIDS, AIDS-RELATED DISEASE

___Yes ___No DRUG AND ALCOHOL TREATMENT

___Yes ___No PSYCHOLOGICAL/PSYCHIATRIC INFORMATION, INCLUDING DIAGNOSIS AND TREATMENT

___Yes ___No PATHOLOGY SLIDES, X-RAYS, VIDEOTAPES, PHOTOGRAPHS

___Yes ___No GENETIC SCREENING

Information to be released: (Please check all that apply including specific date range) This authorization will expire _____ or upon 1 year from date of execution and the undersigned may revoke this authorization in writing.

_____ Entire Medical Record
_____ Hospital Stay/Discharge/Operative Report
_____ Immunizations
_____ Lab &/or Pathology Report(s)
_____ Prior Delivery
_____ Other

Signature: _____ Date: _____

Patient / Guardian

Witness: _____ Date: _____