Family Practice Clinic
1522 East A Street, Casper WY 82601
Main Office: 307-234-6161 Fax: 307-234-7032
Medical Records: 307-232-6051 Fax: 307-234-7027

Authorization Form to Release Patient Health

Patient Name: ____________________________________ Other Names: _________________________________ Medical Record # (if known): _______________________ Date of Birth _________________________________
Address: ____ City: _______________ State: ______Zip: _________

This Authorization is Made for the Following Purpose

☐ Wish to obtain a personal copy of my records ☐ Transferring care away from UW Family Practice ☐ Continuum of Care
☐ Transferring care away from UW Family Practice ☐ Transferring care TO UW Family Practice
☐ Other: ____

Patient is being Treated at UWFPC by Dr.: ________________________________ Next Scheduled Appt is: ______________________

I hereby authorize the University of Wyoming to (check one)

(PLEASE USE A SEPARATE FORM FOR EACH ORGANIZATION/PROVIDER/FACILITY)

☐ Release (send my records) to: ☐ Request (have my records sent to UW) from:

Organization/Provider/Facility:
____

Address: _____________________________________ City: _______________ State: _________ Zip:_____________

Phone: ____ Fax: ____

Health Information to be Released

__ ALL Medical Records __ Discharge Summaries __ Operative Reports __ Radiology Reports
__ Lab/Pathology Reports __ED Records __ Clinic Notes __ Other: _______________________________________

Sensitive Records

Specific patient authorization is required; **INITIAL** and **DATE** beside the following records you are authorizing to be released:

____-____-____ /_______ Pain Management ____-____-___ _/________ Sexually Transmitted Diseases
____-____-____ /_______ Mental Health Treatment ____-____-____ / _______ Alcohol/Drug Abuse
____-____-____/_______ AIDS/HIV Treatment ____-____-____ / _______ (Other): _________________________

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Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to Wyoming Family Practice. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire in **one (1) year** from the date signed below unless another date or event is entered here _______________
*(**Note: If the disclosure is to an employer or financial institution, this authorization will expire 90 days from the date signed by you)*

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Signature of Patient/Legal Representative

___________________ _____________________________________ _______________________________
Date Signature of Patient/Legal Representative Relationship to the Patient

Signature of Patient/Legal Representative

Minor: A minor patient's signature is required to release the following information : 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older): 2) Substance abuse and mental health treatment (age 13 and older).

___________________ _____________________________________
____
Date Signature of Patient/Legal Representative Relationship to the Patient