Family Practice Clinic

1522 East A Street, Casper WY 82601, 307-234-6161
Fax: 307-234-7027 or 307-234-7032

Authorization to Release Patient Health Information

Patient Name _____ Medical Record # (if known) _____

Date of Birth _____/_____/_____ ☐ I am transferring my care away from UW Family Practice

I authorize the following organization to release information as stated below from the patient health information record:

Information to be Released *FROM:*	Information to be Released *TO:*
☐ Wyoming Family Practice Clinic	☐ Wyoming Family Practice Clinic
☐ _____ Organization	☐ _____ Organization
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

Information to be Released

Dates of service for records requested: Beginning _____ Thru _____

☐ Discharge Summaries ☐ Operative Reports ☐ Radiology Reports ☐ ED Records ☐ Lab/Pathology Rpt

☐ Clinic Notes ☐ Radiology Films ☐ All Medical Records ☐ Other (please Specify) _____

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 90 days 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)

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐ **Mental Health Treatment** ☐ **Sexually Transmitted Diseases** ☐ **AIDS/HIV Treatment** ☐ **Alcohol/Drug Abuse Treatment (including pain management)**

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