UNIVERSITY OF WYOMING

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's Health Information (Black Ink ONLY)

Patient Name: _____ Other Names: _____
Phone #: _____ 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
☐ Transferring care TO UW Family Practice ☐ Continuum of Care
☐ 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: AND/OR ☐ Request (have my records sent to UW) from:

Organization/Person:
_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____Fax: _____

Health Information to be released:

__ Entire Medical Records __ Discharge Summaries __ Operative Reports __ Radiology Reports __Immunization Record
__ 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
_____-_____-_____/_____ Mental Health Treatment
_____-_____-_____/_____AIDS/HIV Treatment
_____-_____-_____/_____ Sexually Transmitted Diseases
_____-_____-_____/_____ Alcohol/Drug Abuse
_____-_____-_____/_____ (Other): _____

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)*

Signature of Patient/Legal Representative

_____ _____ _____
Date Signature of Patient/Legal Representative Relationship to the Patient

_____
(PRINT NAME)