Wyoming Medical Center

1233 East Second St. Casper WY 82601 Phone: 307-577-2436/ Fax: 307-233-8133 (Hours: Mon–Fri, 9:00 am- 4:00 pm)

Authorization to Release Patient Health Information

1. PATIENT INFORMATION

Patient Name_____

Phone: ( )-_____-_____ Date of Birth: (m/d/y): _____ / _____ / _____

Patient address: _____

2. INFORMATION TO BE RELEASED FROM (select one)

❑ Wyoming Medical Center ❑ Wyoming Health Medical Group: Clinic (required):_____

3. INFORMATION TO BE RELEASED TO

Name: _____

Address: _____

Phone: ( )-_____-_____ Fax: ( )-_____-_____

4. PURPOSE OF RELEASE

❑ Continuing Care ❑ Copies for Own Use ❑ Insurance
❑ Legal ❑ Other: _____

5. INFORMATION TO BE RELEASED

❑ Emergency Department Records ❑ Discharge Summaries ❑ Labs/Pathology
❑ Radiology Reports ❑ Radiology Images ❑ Clinic Notes
❑ Billing ❑ Operative Report ❑ Other _____

NOTE: Billing and Radiology films are processed by their respective departments

6. DATES OF VISIT(S) BEING REQUESTED

_____/_____/_____ to _____/_____/_____

7. FORMAT

❑ Paper ❑ Disk

8. FEES

Reasonable fees will apply

9. INFORMATION TO BE RELEASED

- This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information without the specific consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.
- I understand that I may revoke this authorization, in writing, at any time except to the extent that Wyoming Medical Center has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Chief Privacy Officer, 1233 E. Second St., Casper, WY 82601 or fax (307)233-8133, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which the authorization expires is: _____, or one year..
- I understand that Wyoming Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law, if the recipient is not a "covered entity".
- I understand that the information being disclosed may contain information from non-WMC providers and that information may not be complete.

10. SIGNATURE

Print/Sign Name of Patient or Legal Responsible Party: _____ _____
Print Signature

Date: _____ / _____ / _____ Legal Representative's Authority to Act for Patient: _____

STAFF USE ONLY: **ROI DEPARTMENT**: Request has been forwarded to: ❑ Radiology ❑ Billing ❑ Cath Lab
❑Other: _____

CLINICAL STAFF: Has this request been processed? ❑ **YES Records** were given to patient. Please scan release into patient's chart
❑ **NO** Please process and send out accordingly.