Wyoming Health
Medical Group LLC
Wyoming Medical Center

Centralized Medical Records

1233 E. Second St., Casper, WY 82601

Phone: 307-577-2089 Fax: 307-233-8133

Records are requested from:

☐ SAGE PRIMARY CARE ☐ CASPER PULMONARY ☐ WYOMING BRAIN & SPINE
☐ WYOMING NEPHROLOGY ☐ WEIGHT MANAGEMENT ☐ WYOMING ENDOCRINE &DIABETES
☐ MESA PRIMARY CLINIC ☐ ADVANTAGE ORTHOPEDICS ☐ IMMEDIATE CARE

MEDICAL RECORDS REQUEST *required fields

*Patient Name: ______________________________

*Telephone #: ______________________________

*Date of Birth: ________________ Social Security Number: ________________

RELEASE FROM	RELEASE TO
*Name:	*Name:
*Address:	*Address:
*Phone #:	*Phone #:

Purpose for disclosure: ______________________________

Date(s) of service to be disclosed: ______________________________

Information to be disclosed

___ Entire Medical Record ___ Clinic notes/History & Physical ___ Discharge summary
___ Procedure Reports ___ Laboratory/Pathology Reports ___ Radiology Reports/Films
___ Consultation Reports Other: ______________________________

Specific Authorization to Disclose Sensitive Records

I understand that this authorization is to include disclosure of (please initial):

___ Alcohol &/or Drug Abuse Records ___ Psychiatric Records
___ Sexually Transmitted Disease Information ___ HIV/AIDs Information

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 written 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 Health Medical Group, LLC 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 East Second Street, 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/WHMG may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization.
- I understand that the 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.

SIGNATURE: ______________________________ **DATE:** ________________

Printed Name of Legal Representative: ______________________________

Legal Representative's Authority to Act for Patient: ______________________________

----------------------------DISPOSITION OF RELEASE ----- OFFICE USE ONLY -------------------------------

Faxed: __________ Mailed: __________ Patient pick-up: __________ Intake Staff Initials __________