Release of Medical Information Form

☐ **Memorial Hospital of Carbon County**
2221 W. Elm Street
Rawlins, WY 82301

☐ **MHCC – Family Practice Clinic**
300 3rd Street
Rawlins, WY 82301

☐ **MHCC Family Practice Clinic – Hanna**
1008 Feldspar Court
Hanna, WY 82327

☐ **MHCC Health Center – Platte Valley**
1504 River Street
Saratoga, WY 82331

Completion of this document authorizes the disclosure and/or use of health information about you. Please be sure to provide all information requested. Failure to do so may invalidate this authorization.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Phone #: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____

To release to: _____Covering the period of healthcare from _____ to _____
(Persons/Organizations authorized to receive the information) (Address – street, city, state, zip code and/or fax number)
The following information:

- Only the following records or types of health information (including any dates):
  ☐Discharge Summary ☐Consultation(s) ☐All pertinent Lab/X-rays/EKG
  ☐History & Physical ☐Operative Report ☐Other: _____
  ☐ER

I specifically authorize release of the following information (initial as appropriate):
_____ Mental Health Information _____ STD
_____ HIV Results _____ Alcohol/Drug Information

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

This authorization will expire _____/_____/_____. If I fail to specify an expiration date, this authorization will expire one (1) year from date on which it was signed.

I understand that once the above information is disclosed, the recipient may disclose information to another party, and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

_____
If signed by legal representative, relationship to patient:

_____
Signature of witness

For Organization Use Only:

Records released on _____

By (initials) _____

Payment Received _____

If no timeframe is specified, three (3) years' worth of medical records will be sent