

Memorial Hospital of Sheridan County, Sheridan, WY.
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PLEASE PRINT CLEARLY

Patient Name: LAST FIRST INITIAL Med Rec #:

Date of Birth: SS#:

I authorize Memorial Hospital of Sheridan County, Sheridan, WY to **RELEASE/OBTAIN** (circle one) medical information from my medical record to:

Name (Physician, Hospital, agency, etc.): _____

Address: _____

City/State/Zip Code: _____

Dates to be included in the release: _____ to _____

No date restriction (release copies from all my records available): _____

Information to be disclosed includes:

- | | | |
|---|---|---|
| <input type="checkbox"/> Complete copy of my records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Care Plans |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Psychiatric Eval/Consult |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Radiology Reports/Film |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> School Records |
| <input type="checkbox"/> PT/ST/OT Reports | <input type="checkbox"/> EKG | |
| <input type="checkbox"/> Medication Administration Record | | |
| <input type="checkbox"/> Other (Please list): _____ | | |

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information _____ (initial). If not applicable, check here _____.

The information will be used for (Check One):

Continuing Care Insurance purposes Personal Legal purposes Viewing only

I understand that:

My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

This authorization will automatically expire six months from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. To revoke this authorization, I must do so by submitting my request in writing to the Health Information and Records Department.

Signature of Patient/Plan Member/Guardian Date: _____

Relationship to Patient if signed by other than the patient:

Prior to release, the following must be provided:

- Photo ID (valid Drivers License and/or Passport) _____
- Copy of photo ID, if requesting by mail or facsimile _____
- Physical street address for records that are to be mailed (NO PO boxes) _____
(If not the patient, state relationship)

FOR OFFICE USE ONLY (initial by each item)

Received: _____ Completed by _____ Faxed by: _____ ID Checked: _____