SHERIDAN MEMORIAL HOSPITAL

Authorization to Release or Obtain Health Information

1401 W. 5th Street Sheridan, Wyoming 82801 Phone: (307) 672-1070 / Fax: 307-675-6762

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED / OBTAINED

___ Specific Dates: _____ / _____ / _____ to _____ / _____ / _____ Provider/Clinic Name: _____

___ Complete Medical Record	___ Discharge Summary	___ Radiology Images
___ History and Physical	___ Discharge Instructions	___ Home Health & Hospice Plans of Care
___ Consultation	___ Psychiatric Evaluation / Consult	___ Clinic Notes
___ Physician Orders	___ Emergency Department Reports	___ Therapy Notes (PT / OT / ST)
___ Procedure Note	___ Laboratory Results / Reports	___ Billing / Demographics
___ Progress Note	___ Pathology Results / Reports	___ Appointment Dates
___ Medication Information	___ Radiology Results / Reports	___ Other: _____

___ May testify as a witness in civil matters involving my care _____ (Provider Name)

Initial: _____ Yes _____ No: I agree to the release of medical records containing a diagnosis or reference to the following conditions: behavioral health / psychiatric care; genetic testing drug and alcohol abuse, sexually transmitted diseases, human immunodeficiency virus (HIV); or acquired immune deficiency syndrome (AIDS)

☐ **RELEASE TO** ☐ **OBTAIN FROM**

Name: _____ Phone _____ Fax _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____
Caregiver ONLY

FORMAT

___ Paper ___ Electronic
___ Verbal ___ Other _____

PURPOSE OF RELEASE

___ Insurance ___ Legal ___ Continuing Care
___ Personal use ___ Other _____

I UNDERSTAND THAT

- I am authorizing Sheridan Memorial Hospital (SMH) and our affiliates and clinics to Release / Obtain the above-selected information To / From the above- identified party. The information released pursuant to this authorization may be **re-disclosed** by the recipient as it may no longer be protected by the HIPAA Privacy Rule.
- I may **revoke** this authorization at any time except to the extent that information has already been released pursuant to this authorization. To revoke this authorization I must submit a request in writing to the address provided above (ATTN: Health Information Management).
- SMH may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization.

EXPIRATION DATE: ☐ 6 months ☐ 1 Year ☐ Other: _____

Signature of Patient/Guardian/Legal Representative	Date
Relationship to Patient if signed by other than Patient	Date

STAFF USE ONLY ___Phone ID verification of patient, caregiver, or legal representative requires two staff signatures _____ / _____

___ Photo ID (Valid Driver's License, State our County ID, Passport) ___ Copy of photo ID (Fax or mail) Other: _____

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