SHERIDAN MEMORIAL HOSPITAL

Authorization to Release or Obtain Health Information

1401 W. 5th Street Sheridan, Wyoming 82801 (307) 672-1070

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

MY PROVIDER (Name) _____ ☐ May consult with law enforcement personnel

☐ May participate in legal proceedings including consulting with counsel prior to trial, testifying in depositions and testifying at trial

INITIAL: _____ Yes _____ No I agree to the release of medical records containing the following: genetic testing results; substance use disorder records (42 C.F.R Part 2 Programs); human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) testing and results; and psychotherapy records.

☐ **RELEASE TO** ☐ **OBTAIN FROM**

Name: _____ Phone _____ Fax _____

Address: _____ Date of Birth: _____ **Caregiver ONLY**

City: _____ State: _____ Zip: _____

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: ☐ One time release ☐ 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 ___ 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: _____

HIM Dept. Fax: 307-675-6762

Dept. / Clinic Fax: