AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORDS) BY FAMILY PHYSICIANS OF LARAMIE

1. PATIENT INFORMATION

Name: ______________________________________ Date of birth: _____________________

Address: ____ City: ___________ State: _____ Zip: ___________

Phone: _______________________________ Cell phone: ________________________

2. RECIPIENT AUTHORIZATION I,____, do hereby authorize

Patient name or representative

FAMILY PHYSICIANS OF LARAMIE

2710 HARNEY STREET, SUITE 202 LARAMIE WY 82072 PHONE: (307) 742-3242 Fax: (307) 742-3282

TO RELEASE MY RECORDS TO,____

Provider or service e.i. Family Physicians of Laramie

Street address_______________________________________ Phone_________________FAX: _______________

3. INFORMATION TO BE RELEASED- **Please check all that apply and specify dates. To obtain a copy of test results, procedure And/or visit note(s) that was done at another care facility, please contact that facility directly**

☐ **Visit notes: ____________** ☐ **ECG/echo: ___________** ☐ **Mammograms________________________________**

☐ **Immunizations: _________** ☐ **Lab reports:_________** ☐ **X-ray report:________________________________**

☐ **Pathology: ____________** ☐ **Stress tests: _________** ☐ **Other: _____________________________________**

☐ **Entire medical record from: ______/_______/_______To:_____/_______/______**

4. PURPOSE OF INFORMATION RELEASE

☐ **Further medical care______________** ☐ **Payment of insurance claim_____________________________________**

☐ **Legal investigation______________** ☐ **Applying for insurance____**

☐ **Vocational rehabilitation Evaluation________________** ☐ **Disability determination_______________________ ___**

☐ **At the request of the individual___________________** ☐ **Other (specify)__________________________________**

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5. INCLUSION OF PRIVILEGED INFORMATION

- I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by Federal regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic, sexual abuse, or developmental disabilities that is protected by MGL c111, such information will be included in this disclosure.

If you do **NOT** wish to have any of the above information released, please specify:____

6. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to the Family Physicians of Laramie medical records service, except to the extent that medical record service has already completed the action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release Family Physicians of Laramie, from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosure of the specified protected health information to the recent above for a period of six months, and it automatically expires six months after the date this form is executed.

7. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:_____________________________DATE:______________

Personal representative, print name: ____

If signed by a personal representative, state your relationship to patient and/or reason authority for signing:

Patient is : ☐ minor ☐ incompetent ☐ disabled ☐deceased

Legal authority: ☐ parent ☐ legal guardian ☐ next of kin of deceased

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Family Physicians of Laramie

Date received _______ Received by_________________________________ ID provided_________ MRN_________

Date released _______ Processed by __________________________ ☐ **Sent by mail** ☐ **Picked up in person**