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

Name: _____
Date of Birth: _____
Phone: _____
Address: _____

1. **I, _____, do hereby authorize the release of my medical records.**

FROM: **FAMILY PHYSICIANS OF LARAMIE, LLC.**
2710 HARNEY STREET, SUITE 100
LARAMIE, WY 82072
PHONE: (307) 742-3242

TO: _____ **Fax:** _____ **Phone:** _____

2. **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 were done at another care facility, please contact that facility directly

- ☐ **Visit notes**_____
- ☐ **Immunizations**_____
- ☐ **Pathology**_____
- ☐ **ECG/echo**_____
- ☐ **Lab report(s)**_____
- ☐ **Stress test(s)**_____
- ☐ **Entire medical record**_____
- ☐ **Mammogram(s)**_____
- ☐ **X-ray report(s)**_____
- ☐ **Other** _____

3. **PURPOSE OF INFORMATION RELEASE**

- ☐ **Further medical care**_____
- ☐ **Legal investigation**_____
- ☐ **Vocational rehabilitation evaluation**_____
- ☐ **At the request of the individual**_____
- ☐ **Payment of insurance claim**_____
- ☐ **Applying for insurance**_____
- ☐ **Disability determination**_____
- ☐ **Other (specify)**_____

4. **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, generic 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: _____

5. **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.

6. **SIGNATURE OF PATIENT OR PERSONAL PRPRESENTATIVE:**_____ **DATE:** _____

Personal representative, print name: _____

This Medical Records request will expire 1 year from the date of signature.