Cheyenne Regional

Authorization to Release Health Care Information and/or Behavioral Health Care Information

Health Information Management
Cheyenne Regional Medical Center
2600 E 18th Street Cheyenne, WY 82001;
Fax (307) 432-3108.
Phone (307) 633-7925

(1) Patient

Name	Previous Name(s)
Birth Date	Phone Number

(2) Information Released FROM

☐Cheyenne Cardiology Associates ☐ Cheyenne Children's Clinic ☐ Cheyenne Family Medicine
☐ Cheyenne Multi-specialty: _____ ☐ Cheyenne Oncology/Hematology ☐Cheyenne Plaza Primary Care ☐ Cheyenne Vascular ☐Consultant In Surgery ☐ CRMG Endocrinology ☐ CRMG Internal Medicine
☐ Family First ☐ Summit Spine & Neurosurgery ☐ Urgent Care ☐ Weight Loss ☐ Wyoming Orthopedics ☐ Wyoming Sleep Disorder ☐Behavioral Health Services - OP ☐ Davis Hospice ☐ Wound Care ☐ Palliative Care ☐ Ambulatory Infusion ☐ *Cheyenne Regional Medical Center* ☐ *Inpatient* ☐ *Outpatient*

FROM Other Clinic/Provider:

Address	City	State	Zip Code

(3) Information Disclosed TO

Individual/Facility/Organization **OR** ☐ **SELF**

Attn/Dept:	Phone Number		Fax
Address	**City**	**State**	**Zip Code**

(REQUIRED) Dates of Service FROM: _____ TO:_____ include:

(4) Health Information to be Released

Provider Dictation/Notes	Diagnostics	Miscellaneous	Miscellaneous Continued
☐ MD Notes	☐ Echo(s)(*)	☐ Progress Notes	☐ Radiology Images (CD)
☐ ER (*)/Urgent Care Record	☐ EKG/Tracings(*)	☐ Immunizations	☐ Billing Information
☐ History & Physical(*)	☐ LAB(s)(*)	☐ Medications	
☐ Consults(*)	☐ Pathology Reports(*)	☐ HIV test results	☐ Abstract Record (includes *)
☐ Operative/Proc Note(*)	☐ Radiology Reports(*)	☐ Treatment Plans	☐ Complete Record for locations
☐ Discharge Summary(*)	☐ EEG Reports	☐ Nursing Records	listed in Box 2 above
☐ Psych Eval	☐ Sleep Studies		
☐ BH Evals/Assessments			

Other (please specify) _____

(5) Purpose of Disclosure

☐ Personal ☐ Continuity of Care ☐ Worker's Comp ☐ Insurance ☐ Disability ☐ Legal ☐Other _____

(6) Delivery Method

*There may be a charge/fee for copies of records. **Information needed by:** _____

Information to be released on: ☐ ***MyChart*** ☐ Paper ☐ CD

Sent by: ☐ FAX ☐ MAIL ☐ PICK UP BY Patient *or Designee* _____

(7) Authorization

I hereby authorize Cheyenne Regional to release the health information indicated above that is contained in my patient record to the Recipient named above. I understand and acknowledge the release to include by initialing:
_____Treatment for mental illness _____ Alcohol/drug abuse _____HIV/AIDS test results or diagnoses.
This authorization does not include permission to release outpatient Psychotherapy Notes as defined as notes that document private, group, or family counseling sessions that are separated from the rest of a patient's medical record. This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the recipient may no longer be protected by law.

_____ _____

Signature Date (Expires one year from signature date)

(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

☐Parent ☐ POA ☐Guardian ☐ other _____ _____

Relationship to Patient *(if not patient)* Expiration Date

Instructions for Completing Authorization to Release of Information and/or Behavioral Health Care Information

To protect the privacy of our patients and to maintain the confidentiality of their personal health information, we must obtain a valid and legible authorization to disclose personal health information.

1. Patient: Print the patient's - full, legal name - Maiden, &/or any previous names
-Birth date -Patients phone number (if we have questions)

2. Information Released FROM: Check only the Cheyenne Regional sites where you have received care and who you want to release your information.

3. Information disclosed TO: Print the name of the individual/facility/organization who is to receive the information along with their full/complete address, city, state, and contact number.

4. Health information to be released:

5. Purpose for disclosure: Check appreciate box or write in if other purpose.

6. Delivery Method: A box must be checked whether a My Chart, CD or paper will be released along with the dates of service needed. Please denote if information is to be mailed, faxed, or picked up. The patient's identity must be verified by ***via photo ID***. Only the patient may pick up the information, unless the patient authorizes in writing that another person may. Records for pick up will be held at CRMC Medical Records regardless of any clinical information requested for 30 days and then destroyed.

7. Authorization: The authorization will terminate in one year unless specified otherwise. Your medical records generated after the date of your signature will not be released unless you specially authorize such by checking the box. The patient or legal representation must sign and date the authorization. (If legal representative, a copy of verification documentation will be needed along with the authorization.)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information, I can contact the Health Information Department.

Mail or Fax the completed and signed authorization to:

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