Cheyenne Regional

Authorization to Disclose Health Information to Family or Other

STAMPER OR PATIENT LABEL

Patient's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize Cheyenne Regional to disclose health information to the following contact(s):

Contact #1

Name: _____ Relationship to me: _____

Home Phone: _____ Alternate Phone: _____

Contact #2

Name: _____ Relationship to me: _____

Home Phone: _____ Alternate Phone: _____

The information that may be disclosed or discussed is related to: _____,
(e.g. current treatment, related to incident)

for the purpose of: _____, and may include the following:

- ☐ Treatment and Progress Notes
- ☐ Treatment Plans
- ☐ Financial Records
- ☐ Nursing Records
- ☐ Lab(s)
- ☐ Medications
- ☐ Other (Please Specify) _____

Once your health information has been disclosed, re-disclosure of your health information by the recipient may no longer be protected by law. You may revoke this authorization in writing at any time. Please note that cancellation by telephone must be confirmed in writing. Your revocation will not affect any disclosure made under this authorization prior to your revocation.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. 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.

By signing this form I understand that Cheyenne Regional Medical Center may discuss past, present, or future health care issues with the above named contacts from _____ through _____

Start End (not more than 1 year from the date of this authorization)

Signature: _____ Date: _____

If Personal Representative Signed:

Personal Representative Name: _____

Relation to Patient: _____