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
Email: CheyenneRegionalHIM@crmcwy.org

(1) Patient

Legal Name	Preferred/Previous Name(s)
Birth Date	Phone Number

(2) Information Released FROM

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

(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

☐ Abstract Record (includes *)	☐ Discharge Summary*	☐ Radiology Reports*+	*Miscellaneous Continued*
Provider Dictation/Notes	☐ Psych Eval #	☐ EEG Reports	☐ HIV test results #
☐ MD Notes +	☐ BH Evals/Assessments #	☐ Sleep Studies	☐ Treatment Plans
☐ ER */Urgent Care Record	*Diagnostics*	*Miscellaneous*	☐ Nursing Records
☐ History & Physical*	☐ Echo(s)*	☐ Progress Notes	
☐ Consults*	☐ EKG/Tracings*	☐ Immunizations	☐ Radiology Images (CD)
☐ Operative/Procedure Note*	☐ LAB(s)*+	☐ Medications	☐ Cardiac Imaging (CD)
☐ L&D Summary	☐ Pathology Reports*		☐ Billing Information

Other (please specify) _____ ☐ Complete Record
+ available on MyChart; # initials required

(5) Purpose of Disclosure

☐ Personal ☐ Continuity of Care ☐ Worker's Comp ☐ Insurance ☐ Disability ☐ Legal ☐Other _____
*There may be a charge/fee for copies of records.

(6) Delivery Method

Information to be released on: ☐ ***MyChart*** ☐ Paper ☐ CD **Information needed by: _____**
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.
1. 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. **2.** I may revoke this authorization at any time in writing, but if I do, it will not have any impact on any actions taken prior to receiving the revocation. This authorization and consent will expire one year from the date of authorization written below. **3.** I understand that the recipient of my health information may be charged for the service of releasing medical information. **4.** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. **5.** Once your health care information is released, re-disclosure of your health care information by the recipient may no longer be protected by law.

_____ _____
Patient's/Patient Representative's 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 ☐ ID verified by: _____
Relationship to Patient *(if not patient)*

This authorization will expire one year from signature date unless otherwise stated: _____

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 preferred/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: Dates of Service requested is *REQUIRED*. This authorization can only be used for the items and the dates of service selected. Abstract of Records is commonly what is needed by the patient and/or the care provider. Items with an * are included in the abstract. Portions of the medical records available on MyChart are +. Items requiring special permission are #.

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

6. Delivery Method: A box must be checked whether My Chart, CD or paper is used to receive medical records. Please indicate if information is to be mailed, faxed, or picked up. Only the patient may pick up the information, *unless* the patient authorizes in writing that another person may. The patient's identity must be verified by ***via photo ID***. If a designee is picking up records for a patient, they must bring a ***photo ID***. Records for pick up will be held at CRMC Medical Records for 30 days and then destroyed.

7. Authorization: Medical records specific for 1. Treatment for Mental Illness 2. Alcohol/drug abuse and 3. HIV/AIDS test results or diagnoses require special permission (#) to be released and will not be provided unless the boxes are initialed in this area. The authorization will terminate in one year unless specified otherwise. Medical records generated *outside the dates of service listed* and/or *after the date of patient signature* will not be released. The patient or legal representative must sign and date the authorization. (The date cannot be in the future.) Legal representative *must* supply a copy of ID verification along with the authorization.

I understand that authorizing the disclosure of this health information is voluntary.

- A signature is required to receive my medical records.
- I may refuse to sign this authorization and understand that my refusal to sign will not impact my ability to obtain treatment, payment, enrollment, or eligibility for benefits.
- 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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