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

Section	Details
(1) Patient	Legal Name: / Preferred/Previous Name(s):
	Birth Date: / Phone Number:
	Address: / City: / State: / Zip:
(2) Information Released FROM	☐ ***Cheyenne Regional Medical Center*** ☐ ***Inpatient*** ☐ ***Outpatient***
	☐ **CRMG (Physician Clinics):** ____________
(3) Dates of Service	**Dates of Service: FROM:** ____________ **TO:** ____________ (required)
(4) Information Disclosed TO	Individual/Facility/Organization **OR** ☐ **SELF**:
	Attn/Dept: / Phone Number: / Fax:
	Address: / City: / State: / Zip Code:
(5) Health Information to be Released	☐ **Abstract Record (most commonly requested)** **Check for specialty items** ☐ Radiology Images (CD) ☐ Cardiac Imaging (CD) ☐ Billing Information ☐ Other (specify below): ____________ ____________ ____________ ____________ ____________
	Check if only need individual reports *Provider Dictation/Notes* ☐ MD Notes ☐ ER /Urgent Care Record ☐ History & Physical ☐ Consults ☐ Operative/Procedure reports ☐ Discharge Summary ☐ Other (specify below): ____________ ____________
	Check if only need individual reports *Diagnostics* ☐ Echo(s) ☐ EKG/Tracings ☐ LAB(s)/Pathology reports ☐ Radiology Reports *Miscellaneous* ☐ Immunizations ☐ Medications ☐ Complete Record
	Behavioral Health Services ☐ Psych Eval ☐ BH Evals/Assessment ☐ Other: ____________ ____________ **If you are requesting records for alcohol/substance abuse treatment along with any medical information, you are required to complete a separate authorization.**
(6) Sensitive Information	**By initialing, I authorize release of the following sensitive information:** **_____Treatment for mental illness _____ Alcohol/drug testing _____HIV/AIDS test results or diagnoses** ***These items will not be released unless initialed.***
(7) Purpose of Disclosure	☐ Personal ☐ Continuity of Care ☐ Workers' Comp ☐ Insurance ☐ Disability ☐ Legal ☐Other ____________ There may be a charge/fee for copies of records.
(8) Delivery Method	Information to be released on: ☐ ***MyChart*** ☐ Paper ☐ CD **Information needed by:** ____________ Send by: ☐ FAX ☐ MAIL ☐ PICK UP by Patient *or Designee* ____________ ☐ Email: preferred email address ____________ ☐ Encrypted ☐ Unencrypted
(9) Authorization	**I hereby authorize Cheyenne Regional to release the health information indicated above to the Recipient named.** **1.** This authorization does not include permission to release Psychotherapy Notes 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. **3.** I understand fees for copy service may apply. **4.** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. **5.** Information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

____________________ / ____________________ ____________

Patient's/Patient Representative's Signature ***Print Name of Signee*** **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)*

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

click on email address to send directly CRMC HIM: Email: CheyenneRegionalHIM@crmcwy.org

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.

A photo ID is needed to verify the identity of the requesting party.

This authorization can only be used for the types of records and the dates of service selected.

1. Patient: Print - Full, legal name – (please also list patient's preferred or previous names)
- Birth date (month, day, year)
- Patient's phone number (in case there are any questions)

2. Information Released FROM: We only have medical records for our two entities;
- ✓ Cheyenne Regional Medical Center (the hospital and its outpatient departments)
- ✓ Cheyenne Regional Medical Group (Physician-based clinics)
- ✓ If you only want a specific physician, please print the name of that physician.

3. Dates of Service: Please provide dates of service for the records you are requesting, or specific event. This helps us provide you with accurate information.

4. Information Disclosed TO: Print the name of the individual/facility/organization who is to receive the information along with their full address, city, state, contact number and fax number, if applicable. If the request is for yourself, please check **SELF.**

5. Health Information to be released: An Abstract of Records is most commonly requested as it usually contains the information needed for any further treatment. The abstract contains (1) Provider Documentation (ED Notes, H&P, Discharge Summary, Operative/Procedure Notes, Consultations, etc., but not daily progress notes) and (2) Diagnostic Reports (Labs, Pathology results, X-Rays, Cardiology testing, etc.) If other items are needed, check the appropriate boxes or write in the items on the space provided.

****If you are requesting alcohol/substance abuse treatment records, you are required to complete a separate authorization. ****

6. Sensitive Information: *Medical records specific for (1) Treatment for Mental Illness (2) Alcohol/drug testing and (3) HIV/AIDS test results or diagnoses require special permission to be released and will not be provided unless the appropriate areas are initialed.*

7. Purpose for disclosure: Check the appropriate box indicating why you are requesting the records or select *Other* and write in the reason.

8. Delivery Method: Check the appropriate box indicating how you wish to receive your requested information.
- ✓ The most convenient way to receive your record is by using MyChart.

Only you may pick up your records, *unless* you specify a designee who may pick them up.
- ✓ When picking up your records you must have your ***photo ID***.
- ✓ If your designee is picking up records for you, they must bring a ***photo ID***.

Records for pick up will be held at CRMC Medical Records for 30 days and then destroyed.

9. Authorization: This authorization will terminate in one year unless specified otherwise. We will not release medical records generated *outside the dates of service listed* and/or *after the date of patient signature*. The patient or legal representative must sign and date the authorization. (The date cannot be in the future.) A legal representative *must* supply a copy of their ID, copy of paperwork proving legal representation, i.e. power of attorney, guardianship, living will, death certificate, etc.

Please understand that authorizing the disclosure of this health information is voluntary.
- You may refuse to sign this authorization. Your refusal to sign a release will not impact your ability to obtain treatment, payment, enrollment, or eligibility for benefits.
- You may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.
- Information disclosed by this authorization, except for Alcohol and Drug Abuse records as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

Cheyenne Regional and the patient/requestor acknowledge and agree that this authorization may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

If you have questions about disclosure of your health information, you can contact the Health Information Department.

Mail, Fax, or Email the completed and signed authorization and, if applicable, any documents needed to support legal representation, to:

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