SUMMIT MEDICAL CENTER
Elevating the Standards of HealthCare.

6350 E. 2nd Street, Casper, WY 82609
Medical Records Phone: 307-232-4068
Medical Record Fax: 307-215-0900

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Please note that any missing information/blanks may result in a delay or inability to release.

Patient Name:	Date of Birth:	
Patient Address:		
City:	State:	Zip Code:
Phone Number where you may be reached: Home:	Cell / Other Phone:	

Disclosure of protected health information is made at my request for:

☐ Change of Insurance ☐ Referral ☐ Change of Physician ☐ Personal Records ☐ Legal or Attorney Use

Describe what specific records may be disclosed. Check all that apply:

☐ All Records of treatment ☐ Billing Records ☐ Records from (date) _____ to (date) _____
☐ Lab / Diagnostic results only ☐ Radiology Reports ☐ Physician notes, orders, H&P, DC Summary, etc.
☐ Operative / Procedure Notes ☐ Link/QR Code of Radiology images ☐ Other records (please specify): _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ Information pertaining to drug and alcohol abuse, diagnosis, or treatment (42 CFR 2.34 and 2.35)
☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code 5328, *et seq*.)
☐ Release of HIV/AIDS/Communicable Disease test results (Health and Safety Code 120980 (g))
☐ Release of genetic testing information (Health and Safety Code 124980 (j))

The Facility or Hospital named above is authorized <u>to disclose (provide)</u> the records/information. Persons, facilities, providers or others who are authorized <u>to receive/pick-up</u> the records / information (Please fill in ALL appropriate contact information):

Send to (Name): _____

Send to (Address): _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

How would you like them sent (check all that apply): ☐ Mail ☐ Fax ☐ Call when ready, I will pick-up ☐ In Person Pick-up

Please complete more than one form if multiple disclosures to multiple providers is requested.

Unless otherwise revoked, the Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form. Any services provided after the date of signing will require a new authorization to be completed.

NOTICE: Summit Medical Center and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: 1) to conduct research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing signed by you or your representative, and submit it to the Health Information Management Dept., Summit Medical Center, 6350 E 2nd St, Casper, WY 82609. The revocation will take effect upon receipt of the request. You are entitled to receive a copy of this Authorization.

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____
Signature of Patient (or Patient's Personal Representative, if applicable) Date of Signature

_____ _____
Personal Representative's relationship or legal ability to represent the patient Printed Name of Patient or Personal Representative

Printed Address and Telephone Number of Personal Representative: _____

_____

OFFICE USE ONLY: (Please initial): _____ QR Only / Mail Report _____ QR _____ Mail _____ Fax _____ Patient Pick-Up

Version 3 10.2021