Reset Form

MEDICAL RECORDS RELEASE AUTHORIZATION

OFFICE USE ONLY
M#:_____
Completed On: ____/____/____

PATIENT INFORMATION

Name:_____ Birth Date:_____
Other Names:_____ Service Date(s):_____
Address:_____ City:_____ State:_____ Zip:_____
Phone: Home:_____ Work:_____ Cell:_____
E-mail:_____

INFORMATION TO BE REQUESTED OR RELEASED

☐Emergency Room Report ☐Pertinent Information ☐Physical Therapy ☐Clinic Notes
☐History and Physical ☐Physician Orders ☐Progress Notes
☐Operative Report ☐Laboratory ☐Radiology CD
☐Consultation ☐EKG†/EEG†/Holter Monitor ☐†Radiology Report †Available on Patient Portal
☐Discharge Summary ☐Behavioral Health ☐Drug and Substance Abuse Treatment
☐Other:_____

I authorize IMH to release information to:
Name:_____
Phone:_____ Fax:_____
Address:_____
City, State:_____ Zip:_____

I authorize IMH to obtain information from:
Name:_____
Phone:_____ Fax:_____
Address:_____
City, State:_____ Zip:_____

PURPOSE OF REQUEST
☐Treatment or Consultation ☐By Patient Request
☐Bill or Claim Payment ☐Other:_____

Return To:_____

This consent expires on the date of _____ or not later than one hundred eighty (180) days from the date of the signature.

I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released. Ivinson Memorial Hospital is not responsible for any access or activity between the date of the original signature of this authorization and receipt of the revocation document.

I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and is no longer protected by federal or state privacy laws.

I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Ivinson Memorial Hospital is not liable for breaches of confidentiality arising from unauthorized use of such information.

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis testing, genetic testing and/or other sensitive information, I agree to its release.
Initial Yes:_____ No:_____

I understand that if my medical or billing record contains information in reference to: HIV/AIDS (Human Immunodeficiency Virus)/(Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.
Initial Yes:_____ No:_____

I authorize Ivinson Memorial Hospital to release information on the above named patient to the recipient indicated. Ivinson Memorial Hospital is released from all legal liability that may arise from the release of information requested.

Patient or Authorized Representative Signature:_____ Date:_____

Relationship to Patient:_____

Signature must be verified by IMH staff or must be notarized. See next page for notarial certificate. **OFFICE USE ONLY**

Driver's License:_____ Other Verification:_____

Authorization Received By:_____ Date:_____

Please Note: A flat fee of $5 will be assessed for records maintained electronically. For all other records a fee of $22/hr may be assessed for copying, materials and postage.

Ivinson MEMORIAL HOSPITAL
AN AFFILIATE OF UCHealth

IVINSON MEMORIAL HOSPITAL
255 N 30TH ST, LARAMIE, WY 82072
Phone: 307-755-4560 | Fax: 307-742-1924
www.ivinsonhospital.org

PATIENT IDENTIFIER

MEDICAL RECORDS
RELEASE AUTHORIZATION

OFFICE USE ONLY
M#: _____
Completed On: ____/____/____

State of _____

County of _____

This Medical Records Release Authorization signed or attested before me on

_____ by _____ .
Date Name(s)

(Seal)

_____
Signature of Notarial Officer

_____
Title or Rank
(e.g. Notary Public or rank if active military officer)

My commission expires: _____

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