

# Medical Records Release Authorization

<b>STAFF USE ONLY</b>	
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

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Pertinent Information    | <input type="checkbox"/> Physical Therapy                   | <input type="checkbox"/> Clinic Notes |
| <input type="checkbox"/> History and Physical  | <input type="checkbox"/> Physician Orders         | <input type="checkbox"/> Progress Notes                     |                                       |
| <input type="checkbox"/> Operative Report      | <input type="checkbox"/> Laboratory               | <input type="checkbox"/> Radiology CD                       |                                       |
| <input type="checkbox"/> Consultation          | <input type="checkbox"/> EKG+/EEG+/Holter Monitor | <input type="checkbox"/> †Radiology Report                  | †Available on Patient Portal          |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Behavioral Health        | <input type="checkbox"/> Drug and Substance Abuse Treatment |                                       |
| <input type="checkbox"/> 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: \_\_\_\_\_  
Return To: \_\_\_\_\_

## PURPOSE OF REQUEST

- |  |   |
|--|---|
| <input type="checkbox"/> Treatment or Consultation | <input type="checkbox"/> By Patient Request |
| <input type="checkbox"/> Bill or Claim Payment     | <input type="checkbox"/> Other: _____       |

This consent expires on the date of \_\_\_\_\_ or not later than one (1) year 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. Iverson 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. Iverson 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 Iverson Memorial Hospital to release information on the above named patient to the recipient indicated. Iverson 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 <u>must be verified</u> by IMH staff if completed on site.	<b>STAFF USE ONLY</b>
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.

 <p><b>Iverson</b> MEMORIAL HOSPITAL AN AFFILIATE OF UCHHealth</p>	Iverson Memorial Hospital 255 N 30 <sup>th</sup> St, Laramie, WY 82072 P# (307) 755-4560   F# (307) 742-1924 www.iversonhospital.org	Patient Identifier
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