Wyoming Cardiopulmonary Services, P.C.
1230 East First Street, Casper, Wyoming 82601
(307)266- 3174 **1-800-445-3501** Fax: (307)266-3177
Medical Records Fax: (307)261-6713

Authorization for Release of Medical Record Information

Name:_____ Date of Birth:_____
Address:_____ Patient Acct. No.:_____
City:_____State:_____Zip:_____ Telephone No.:_____

I hereby authorize:

Wyoming Cardiopulmonary Services, PC

To disclose information from my/my minor child's medical records to (name and address):
_____
_____
_____

This information is needed for the following reason: _____

The specific information I wish to have released is (include dates of treatment):_____
_____
_____

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Wyoming Cardiopulmonary Services, PC.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature of Patient Date

Signature of Patient Representative Relationship to Patient Date

Witness

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

| | I DO consent to have this information disclosed. | | I DO NOT consent to have this information disclosed
.

_____ _____
Signature Date

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

| | I DO consent to have this information disclosed. | | I DO NOT consent to have this information disclosed.

_____ _____
Signature Date