Wyoming Cardiopulmonary Services, P.C.

1230 East First Street, Casper, Wyoming 82601 www.wyoheart.com
Phone: (307)266-3174 Toll Free: 1-800-445-3501 Fax: (307)266-3177

Authorization for Release of Medical Record Information

Name: _____Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Telephone No.:_____

I hereby authorize (name and address): _____
_____

To disclose information from my or my minor child's medical records to: **Wyoming Cardiopulmonary Services, P.C. 1230 East 1st Street, Casper, WY 82601 Fax: (307)266-3177**

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, P.C.

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.

Request for records to be sent through an unsecure format: This authorization releases Wyoming Cardiopulmonary Services P.C. from any responsibility pertaining to the unlawful use or disclosure of PHI (Personal Health Information) sent in an unsecure format such as email.

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

OFFICE USE ONLY:
Patient Account Number:_____ **How were records sent:** _____
Date request was completed: _____ **Initials of who completed request:** _____