WyoHeart
Leaders in Cardiology Since 1978

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Authorization for Release of Medical Record Information

Patient Name: _____ Date of Birth: _____
Account #: _____ Address: _____
City: _____ State: _____ Zip: _____ Telephone #: _____

I hereby authorize the release of medical records: **Purpose of disclosure:** _____
☐ **To myself:** please select how you would like to receive your records.
☐ **Print (*please circle one*):** Pick up or Mail to address above ☐ **Email:** _____
☐ **Other:** _____

☐ To: **Wyoming Cardiopulmonary Services, P.C.** From: _____ Address: _____ Phone: _____ Fax: _____	☐ From: **Wyoming Cardiopulmonary Services, P.C.** To: _____ Address: _____ Phone: _____ Fax: _____

Information to be released:
☐ Entire Medical Record ☐ Imaging Reports ☐ Copy of Images on CD ☐ Billing Records
For the Dates of Service: From: _____/_____/_____ To: _____/_____/_____
Specific Records Want Sent: _____

Expiration Date of Authorization: This authorization is effective for one year or 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.

_____ By initialing I give permission to release medical records that may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment.
_____ By initialing I give permission to release medical records may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

_____
Signature of Patient Date

_____
Signature of Patient Representative Relationship to Patient Date

_____
Witness

OFFICE USE ONLY:
How were records sent: _____ **Date request was completed:** _____

Initials of who completed request: _____