AUTHORIZATION TO RELEASE HEALTHCARE RECORDS & INFORMATION

Name: _____ **Date of Birth:** _____

Date of Request:_____

Address: _____ **Phone number:** _____

LARAMIE | REPRODUCTIVE HEALTH CLINIC

To/From: **1252 N 22nd St. Suite A**
Laramie WY 82072
Phone 307-745-5364
Fax 307-745-4164

To/From: _____
Name

_____
Street

_____
City, State, Zip

_____
Phone **Fax**

Specific Information Needed:

_____**Medical Notes**

_____**X-ray Report (specify)** _____

_____**Lab Results Specific date**____ **All**___ **Specific Date**_____

_____**Pap & pelvic Records** ____**All** ___ **Most Recent**

_____**Health History**

_____**Immunization Records**

_____**Complete Record**

Purpose for This Disclosure:

_____**Continuing Medical Treatment**

_____**Insurance**

_____**Consultation**

_____**Attorney**

_____**Other (specify)** _____

***I understand that my health information may include general information related to my mental health, drug or alcohol use, communicable disease, abortion, or other information may consider sensitive. I understand that this authorization is voluntary. I may inspect or copy information to be disclosed as provided in the notice of information. There may be a fee for photocopying this information. Any disclosure carries potential for unauthorized re-disclosure, and release the above entity from any legal liability that may arise from the disclosure of this information. I have the right to revoke the authorization at any time by presenting written request to the above-mentioned entity: however, I understand revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or conditions:_____.**
If I fail to specify this date, event, or condition this authorization will expire after ninety days from today's date except when state or federal regulations specify otherwise. In such situations, the shorter time period shall apply.

I have read and understand the above statements and authorize the disclosure of the information requested above.

Patient Signature:_____ **Date Signed:** _____