Name of Patient: ______________ Date of Birth: ______________ Medical Record # ______________

I hereby authorize ____

(Name and address of Individual or Organization)

to release to ____

(Name and address of Individual or Organization to receive information)

the following information from my medical record for the time period: ______________

______ Cedar Mountain Center	______ Long Term Care Center	______ Rehab(PT/OT)
______ Discharge Summary	______ Pathology Report	______ PFS (Billing)
______ History & Physical Report	______ Laboratory Report	______ Physician Clinics
______ Consultation Report	______ Direct Access Lab	Other (Specifiy) ______
______ Emergency Room Report	______ Radiology Report	______
______ Urgent Care Report	______ Radiology Image (PACS)	For Internal Use by Cody Regional Health Staff Completed By:
______ Operative/Procedure Report	______ EKG Report	

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL, AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING. I specifically authorize the release of the following records:

☐ Psychiatric/Psychological ______ Initials ☐ HIV ______ Initials ☐ Drug and/or Alcohol Dependency ______ Initials

The information is necessary for the following purpose:

______ Diagnosis & Treatment ______ Legal ______ Personal ______________

______ Insurance/Billing ______ Military ______ Other ______________

This authorization shall remain in effect until the following date, event or condition: ______________

If no date, event or condition is specified, this authorization will expire in one (1) year.

1. This authorization remains in effect until the above date, event or condition, unless specifically revoked by written notice to the individual or organization. I understand that this may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality.
2. I understand that authorizing the disclosure of this heath information if voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that received the information is not a health care Provider or health plan covered by deferral privacy regulations, the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

______________________ ______________ ______
Signature of Patient or Legal Representative Relationship Date

______________________ ______________ ______
(if patient is unable to sign, please state reason.) Signature of Witness Date

☐ **CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING CHEMICAL DEPENDENCY RECORDS**
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42- CFR Part 2) prohibits you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.

Cody Regional Health - 707 Sheridan Avenue, Cody, WY 82414 - Phone: 307-578-2780 - Fax: 307-578-2788

RELEASE OF INFORMATION - AUTHORIZATION