HOT SPRINGS HEALTH

Authorization for Release of Information
Health Information Management Dept.
150 East Arapahoe Street
Thermopolis, Wyoming 82443
PH 307-864-3121 FAX 307-864-5007

Patient's Name: _____ Other Names Used: _____

Date of Birth: _____ Phone: _____

Hot Springs Health is hereby authorized to permit: _____

Enter the address/city/state/zip code and phone number where the information can be released:

_____

To review, receive, or provide a copy of pertinent medical records and any information contained therein, whether written or audio taped, saved on computer disk, or any other means of storing and/or exchanging medical information. This release includes information which pertains to and, is subject to the Minimum Necessary Rules. List the specific information this release pertains to.

Date of Service(s): _____

☐ **ER Note**	☐ **History & Physical Note**	☐ **Laboratory Data**	☐ **Other**_____
☐ **Discharge Summary**	☐ **Diagnostic Imaging CD**	☐ **Pathology Report**	
☐ **Operative Report**	☐ **Radiology Report**	☐ **EKG Tracings**	

The record(s) requested is needed for the following purpose: _____

Patient must read and complete information in this section

- It is understood that this authorization to release medical records to the above-named person(s) may be revoked by written notice at any time. However, this authorization shall remain valid until it is either revoked or upon the expiration of sixty (60) days from the date of signature of this release, except to the extent that it may have already been acted or otherwise relied upon.
- It is understood that, unless indicated otherwise, this authorization to release medical records includes permission to release information pertaining to physical and emotional illnesses, including treatment for mental illness, drug or alcohol abuse*. Additionally, information pertaining to communicable diseases, including HIV/AIDS information may also be released.
- I understand that records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Identification Number (D. License #, Passport, etc.) **Witness**

If signed by someone other than patient, please indicate reason why patient is unable to execute.

Check all that apply: ☐ Parent/Guardian ☐ Incapacitated ☐ Other: _____

FOR OFFICE USE ONLY

Prepared by: _____ Released By: _____ Date: _____

Comments: _____

*This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Information used or disclosed pursuant to an authorization may be subject to re-disclosure by the recipient and is no longer protected by this rule.