CODY REGIONAL HEALTH

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)	
_____ Operative/Procedure Report	_____ EKG Report	

For Internal Use by Cody Regional Health Staff Completed By:

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

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RELEASE OF INFORMATION - AUTHORIZATION