Crook County
Medical Services District

Authorization to Release Medical Information

▪PO Box 517 Sundance WY 82729 ▪ Phone: 307-283-3501 ▪ Fax: 307-283-2255

Delivery Status: □ Urgent □ Standard

Patient Identification	Name: _____ Address: _____ City:_____ State:_____ Zip Code:_____ Date of Birth:_____ SSN:_____ Maiden or Other Names Used:_____
Records Released To	Name:_____ Address: _____ City:_____ State: _____ Zip Code: _____ Phone: _____ Fax: _____
Dates of Treatment :	Dates:_____

Purpose of Release: □Insurance/Billing □Treatment □Patient Request □Other:

The following information is requested:

	Lab/ Pathology		Clinic Notes
	History & Physical		PT, OT, ST
	Discharge Summary		OP Report
	Radiography		ER Notes
	Formal Health Record		Other:

Drug, Alcohol, Psychiatric, HIV, AIDS Information: I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and or alcohol abuse, Acquired Immune Deficiency Syndrome (AIDS), and or HIV status.

Please initial: _____

Disclosure:

▪ Information disclosed by this authorization may be subject to re-disclosure by recipient and no longer covered under HIPPA.
▪ I understand that treatment is not conditional upon signing the authorization and will not be affected.
▪ I authorize CCMSD to use and disclose the protected health information as specified above.

Time Limit/ Revocations:

▪ Unless revoked, this authorization expires in 90 days.
▪ Photocopy or facsimile of this authorization is as valid as the original.
▪ To revoke authorization, send written request to the provider or department listed above.

Signature of Patient/ Legal Representative: _____Date:_____

Relationship to Patient: _____

***Picture Identification is required for verification**