AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

Last Name: _____ First Name: _____ Middle: _____
Date of Birth: _____ SSN: _____ Phone: _____

Give the complete name and address of the Medical Facility or organization you are authorizing your Medical Records to be released from.

I authorize:

Willow Creek Family Medicine
4003 Rawlins St
Cheyenne, WY 82001___
Phone: (307) 638-8975
Fax: (307) 634-9267__

Send Records to:

_____

_____

_____

Phone: _____

Fax: _____

Copies of the following information:

Please initial each applicable area in order to authorize release:

____ Mental Health/Developmental Disabilities
____ Drug/Alcohol use/abuse
____ HIV (AIDS) test results/information
____ All Medical Records
____ Abstract of Medical Records (past 3 Years)
____ Immunization Records
____ Test Results
____ Other (Please specify exact information) **ALL RECORDS, including inner office and business notes**

For the purpose of:

___ Continuing Care
___ Insurance Claim
___ Disability Determination
___ Other (Please Specify) _____
____ Personal Copy
____ Legal Claim

Photocopies of this Authorization for Request of medical records shall have the same authority as the original.
I further understand that:

1. I may refuse to sign this authorization and that my refusal will have no impact on receiving treatment.
2. I can inspect or copy any information disclosed under this agreement.
3. My signing this document is voluntary.
4. I can revoke this authorization at any time and the revocation must be **IN WRITING**.
5. The federal Privacy laws will not cover the information released/requested.
6. This authorization is only valid for 90 Days.

Patients 18 and older must sign his/her own authorization. Spouses must sign their own authorization. The information which related to privileged information is subject to the following statement: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. State and Federal law prohibit you from making further disclosure of such information without specific written consent of the person to whom the information pertains or is otherwise permitted by state and federal laws.

Signatures:

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Witness Signature Date