Rocky Mountain Family Medicine LLC

5840 E. 2nd St. Suite 200
Casper, WY 82609
Telephone: 307-315-6133
Fax: 307-315-6134

Medical Records Request

Patient Name:
Address:
Telephone Number:
Date of Birth:
SSN:

Release From:
Physician Office/Name:
Address:
City, State, Zip:
Fax:

Release To:
Rocky Mountain Family Medicine
5840 E. 2nd St. Suite 200
Casper, WY 82609
(fax) 307-315-6134

Purpose for disclosure: _____

Dates of Services Requested: _____

Information to be disclosed:

- ☐ Progress Notes
- ☐ Pathology
- ☐ Billing Records
- ☐ Prescription
- ☐ Lab Reports
- ☐ X-Ray Reports
- ☐ Other: _____

Specific Authorization to Disclose Sensitive Records

I understand that this authorization includes the disclosure of: (initial those that apply)

_____Alcohol and/or Drug Abuse Records
_____Sexually Transmitted Disease Information
_____Psychiatric Records
_____HIV/AIDS Information

*This information is disclosed from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Rocky Mountain Family Medicine, LLC has already relied on this information.
- I understand that I may revoke this authorization by sending or faxing a written notice to Chief Compliance Officer, 2241 Farnum Street, Ste 102 Casper, WY 82609 or fax (307) 315-6134, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which the authorization expires is: _____
- I understand that Rocky Mountain Family Medicine may not condition treatment, payment, enrollment, or eligibility for benefits on the completion of this authorization.
- I understand that the information being disclosed may be subject to re-disclosure by the recipient and may no longer by protected by the Federal Privacy Law, if the recipient is not a covered entity.

Signature:_____ Date:_____

Printed Name of Legal Representative:_____

Legal Representative's Authority to Act for Patient: _____