Rocky Mountain Family Medicine LLC

2241 Farnum St. Suite 102
Casper, WY 82609
Telephone: 307-315-6133
Fax: 307-315-6134

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____
Address: ____
Phone: ____
Date of Birth: ____

RELEASE FROM:

Name: ____
Address: ____
City, State, Zip ____

RELEASE TO: Click to Choose

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The following information is to be disclosed:

- ☐ Progress Notes
- ☐ Pathology
- ☐ Billing Records
- ☐ Prescription
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ Other
- ☐ All Records

Expiration: This authorization shall expire no later than one year from signature date.

I understand that after the custodian of records discloses my health information, it may no longer be protected by privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will no affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected heath information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, (i.e., parent, guardian, power of attorney for healthcare)

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on the authorization.