CAMPBELL COUNTY MEMORIAL HOSPITAL PO BOX 3011 GILLETTE, WY 82717 P (307) 688-1301 F (307) 688-1390 MEDICAL RECORDS RELEASE OF MEDICAL INFORMATION	M# _____ V#_____ R#_____

_____ _____

PRINT NAME OF PATIENT (PRINT PREVIOUS NAME, IF APPLICABLE) **DATE OF BIRTH**

_____ **PURPOSE OF DISCLOSURE:** Patient Care ___ Self ___Other_____

TELEPHONE #

SEND TO: Provider Name/Organization **RELEASED FROM: Provider Name/Organization**

_____ _____

_____ _____

_____ _____

INFORMATION TO BE DISCLOSED: (Approximate Date of Treatment)_____

	Discharge Summary		H&P		ER Reports		EKG Report
	Pathology		Laboratory		Radiology		Wellness
	Operative Report		Rehabilitation		X-ray/Echo Films		
	Psychological Records		Alcohol/Drug		Other		

Home Health of Campbell County, Outpatient Behavioral Health and Wright Clinic maintain their own individual medical records. Please contact them directly to obtain your records. Records requested from CCMH Medical Records Department will not include any of records from these agencies.

I understand that if this authorization includes disclosure of any PSYCHIATRIC, ALCOHOL and DRUG ABUSE records, the records are protected by virtue of the provisions of Federal Regulations 42 C.F.R. Part 2. I make this authorization upon the promise that the following notice shall accompany all disclosures of any ALCOHOL AND DRUG ABUSE records made pursuant to this authorization:

> This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

If Release of information includes Psychiatric, Alcohol, Drug Abuse or HIV results initials are required: _____

I do hereby acknowledge that I have read, am familiar with, and fully understand the terms and conditions of this authorization. We will not condition treatment or payment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996.

_____ _____/_____/_____

PATIENT'S SIGNATURE/LEGAL REPRESENTATIVE'S SIGNATURE **DATE** **Time**

_____/_____

PRINT LEGAL REPRESENTATIVE'S NAME **RELATIONSHIP**

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient.

_____/_____/_____

WITNESS **DATE** **Time**

This authorization expires on _____. If no expiration date is indicated, this authorization will expired 12 months from date of execution. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization.

7181.005 08/2009