

**Centralized Medical Records**

1233 E. Second St., Casper, WY 82601  
Phone: 307-577-2089 Fax: 307-233-8133

**Records are requested from:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> ADVANTAGE ORTHOPEDICS & NEUROSURGERY | <input type="checkbox"/> MESA PRIMARY CLINIC | <input type="checkbox"/> WYOMING ENDOCRINE & DIABETES |
| <input type="checkbox"/> CASPER PULMONARY                     | <input type="checkbox"/> SAGE PRIMARY CARE   | <input type="checkbox"/> WYOMING NEPHROLOGY           |
| <input type="checkbox"/> IMMEDIATE CARE                       | <input type="checkbox"/> WEIGHT MANAGEMENT   |   |

**MEDICAL RECORDS REQUEST** \*required fields

\*Patient Name: \_\_\_\_\_  
 \*Telephone #: \_\_\_\_\_  
 \*Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

RELEASE FROM	RELEASE TO
*Name: _____	*Name: _____
*Address: _____	*Address: _____
*Phone #: _____	*Phone #: _____

Purpose for disclosure: \_\_\_\_\_

Date(s) of service to be disclosed: \_\_\_\_\_

**Information to be disclosed**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Clinic notes/History & Physical | <input type="checkbox"/> Discharge summary       |
| <input type="checkbox"/> Procedure Reports     | <input type="checkbox"/> Laboratory/Pathology Reports    | <input type="checkbox"/> Radiology Reports/Films |
| <input type="checkbox"/> Consultation Reports  | Other: _____   |  |

**\*Specific Authorization to Disclose Sensitive Records\***

**I understand that this authorization is to include disclosure of (please initial):**

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol &/or Drug Abuse Records          | <input type="checkbox"/> Psychiatric Records  |
| <input type="checkbox"/> Sexually Transmitted Disease Information | <input type="checkbox"/> 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 Wyoming Health Medical Group, LLC has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Chief Privacy Officer, 1233 East Second Street, Casper, WY 82601 or fax (307)233-8133, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which the authorization expires is \_\_\_\_\_ or one year.
- I understand that Wyoming Medical Center/WHMG 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 be protected by the Federal Privacy Law, if the recipient is not a "covered entity".
- I understand that the information being disclosed may contain information from non-WMC providers and that information may not be complete.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Printed Name of Legal Representative: \_\_\_\_\_

Legal Representative's Authority to Act for Patient: \_\_\_\_\_

-----DISPOSITION OF RELEASE ----- OFFICE USE ONLY -----

Faxed: \_\_\_\_\_ Mailed: \_\_\_\_\_ Patient pick-up: \_\_\_\_\_ Intake Staff Initials \_\_\_\_\_