*Laramie Physicians for Women and Children, P.C.*
**2710 Harney St. Ste. 100**
**Laramie, WY 82072**
**(307) 745-8991**
**Fax: (307) 745-8167**

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

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

I authorize _____ (the custodian of records) to disclose/release the following information*

(check all applicable):

☐ All records ☐ Pap Results ☐ Doctors Notes
☐ Radiology / Pathology ☐ Annual Exam ☐ Labs
☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

| **Please obtain records from:** | **Please send records to **:** |
|---|---|
| Name: | Name: |
| Address: | Address: |
| Phone: | Phone: |
| Fax: | Fax: |

*****If requesting your records would you like a paper or electronic copy?** (please circle one)*

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the patient can check this box)
☐ For my health care ☐ For payment/insurance ☐ For employment purposes ☐ Other:

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not 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 health 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 (Patient's personal representative) Date Expiration Date (If left blank, expires one year from effective date)

_____
Printed name of patient representative Representative's authority to sign for patient

*You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Practice Administrator 2710 E Harney, Suite 100, Laramie WY 82070*