Laramie Physicians Women & Wellness Clinic

1277 N.15th Laramie, WY 82072
Phone: (307) 745-8991   Fax: (307) 745-8167

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

Please allow 7 to 10 business days to process your records request.

Please complete the following information:

Patient Name: ____

Address: ____

Phone: ____________________________________   Date of Birth:__________________

I authorize Laramie Physicians Women & Wellness Clinic (the custodian of records) to disclose/release the following information: **(Circle all applicable)**

☐All records   ☐Doctors Notes   ☐Radiology / Pathology   ☐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:

The information may be used/disclosed for each of the following purposes. (Circle all applicable)
At my request (only the patient can circle 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 St. Suite 100, Laramie WY 82070

Request Processed by:_____________________ Date: _____________ Records were _________ # of Pages _____________