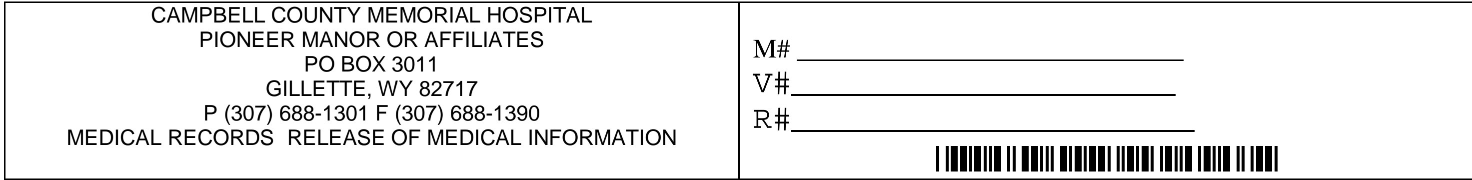
CAMPBELL COUNTY MEMORIAL HOSPITAL
PIONEER MANOR OR AFFILIATES
PO BOX 3011
GILLETTE, WY 82717
P (307) 688-1301 F (307) 688-1390
MEDICAL RECORDS RELEASE OF MEDICAL INFORMATION

M# ____________________________
V#____________________________
R#____________________________

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

______________
**TELEPHONE #** **PURPOSE OF DISCLOSURE:** Patient Care ___ Self ___Other__________________________
**FORMAT:** CD______ PAPER ________

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

______________________________________ ______________________________________

______________________________________ ______________________________________

**If faxing records they may be faxed to an unsecure fax line per patient request initials are required: ___________**

**INFORMATION TO BE DISCLOSED: (Approximate Date of Treatment)___________________________**
**Please check all that apply or describe in other box records to be released. Blank boxes indicate no records to be released.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Discharge Summary | | H&P | | ER Reports | | EKG Report |
| | Laboratory/Pathology | | MARS/Graphics | | Progress Notes | | Wellness |
| | Operative Report | | Rehabilitation | | Rad Reports/Images | | Nursing Notes |
| | Psychological Records | | Alcohol/Drug Notes | | Other | | |

CCMH Hospital, Home Health, Pioneer Manor, Outpatient Behavioral Health, HMR and CCMH owned clinics maintain their own individual medical records. Please contact them directly to obtain your records.

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. We will not condition treatment upon completion of this authorization unless the treatment is one of those types of treatment specified in 45CFR 164.508(b) (4).

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.

COMPLETED BY CCMH STAFF ONLY: Release completed on:_________________ By:__________________________________________

7181.005 01/2014