Campbell County Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Select group from which you are requesting records:
☐ **Campbell County Health** ☐ **Legacy**
☐ **CCMG Clinic** ☐ **Home Health & Hospice**
☐ **Provider** _____

Email: ROI@cchwyo.org
Fax: 307-688-1390
Mail: 501 S. Burma Ave
Gillette, WY 82716

Complete all sections entirely. If this authorization is not complete, it may be returned and result in delay in processing.

Patient name _____ Formerly known as _____ Date of birth _____

Address _____ City/State _____ Zip _____ Phone _____

Purpose of Request: ☐ Continuation of Care ☐ Personal ☐ Legal ☐ Insurance ☐ Other _____

I authorize release to ☐ Self or (Name/Facility) _____

Address _____ City/State _____ Zip _____ Phone _____

Fax_____ (if faxing records, they may be faxed to an unsecure fax line per patient request) **Initials Required** _____

Email _____
I acknowledge the risks associated with information sent via email that is not secured, and CCH is not liable for disclosure, misdirected or intercepted in transmission.

Date of service range (month/year) From: _____ to _____

If you released to self, select method of release: ☐ My Health Connections ☐ Email ☐ Mail

☐ Abstract of record (Discharge Summary, H&P, Operative Records, Consults, Test Results)

☐ Emergency Department Record ☐ History & Physical ☐ Operative Record ☐ Discharge Summary ☐ Office Visit

☐ Immunization Record ☐ Test Results (Lab, pathology, Radiology, and Cardiac) ☐ Itemized Bills ☐ Physical Therapy Notes

☐ Images (mailed or pick up by appointment between 10 am – 2 pm M-F only. Mailed if not Specified. Call 307.688.1300 for appointment)

☐ Legal Record (Standard two years of information, unless otherwise specified, fees may apply): _____

☐ Other _____

Patients' Rights:

- I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/ AIDS related conditions, sexually transmitted diseases, and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy notes or Substance Abuse Disorder notes.
- This authorization will expire one year from date signed.
  I understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail, email or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the insurers to contest a claim under policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. Research participation requires separate authorization by the patient. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are state in the United States Code of Federal Regulations at section 164.524.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Release of Information department where the request was submitted to.
- I understand if I am requesting my information while I am In House/Admitted or receiving on-going services, my record may not be complete, and I will need to request after services are completed and finalized. Records provided will be for treatment on the date of signature and/or Prior to signature date.
- There may be a charge for copies of records.

_____ _____
Signature of Patient or Legal Representative Date

Relationship to patient: _____

Supporting documentation of authority must be provided. (Guardianship, Executor of Estate, Power of Attorney)

Release of Information; Medical Records: REV: 6/2015; 10/2016; 7/2017; 11/2023; 12/2025 10/10/2016.
Committee Approval: Medical Records 11/15/2023

Date Initiated/Revised: 3/2013; 6/16/2015; 07/06/2017; 11/15/2023, 12/11/2025