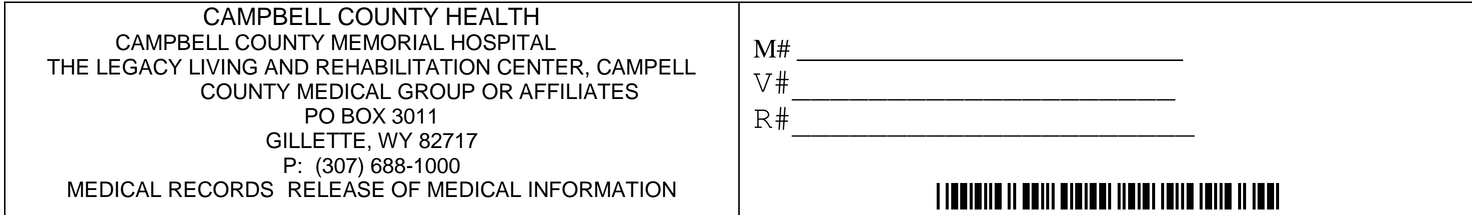

CAMPBELL COUNTY HEALTH
CAMPBELL COUNTY MEMORIAL HOSPITAL
THE LEGACY LIVING AND REHABILITATION CENTER, CAMPELL COUNTY MEDICAL GROUP OR AFFILIATES
PO BOX 3011
GILLETTE, WY 82717
P: (307) 688-1000
MEDICAL RECORDS RELEASE OF MEDICAL INFORMATION

M# ___________________________
V# ___________________________
R# ___________________________

____ ______________________

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

______________ **PURPOSE OF DISCLOSURE:** Patient Care ___ Self ___Other__________________________

TELEPHONE # **FORMAT:** CD______ PAPER ________

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

____________________________________ ____

_______________________________________ ____

PH: _______________ FX: ______________ PH:________________ FX:_______________

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)__________________________

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

CCH Outpatient Behavioral Health, Campbell County Medical Group and HMR 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.

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:____

Pages released: ___________________________________