

 **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do hereby understand and consent to the release of confidential information in the custody of:

Outpatient Radiology 419 S Washington St, Suite 101 Casper, WY 82601 Phone: 307.232.5041 Fax: 307.577.0443

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TO BE
RELEASED
TO:**

Hospital/Facility/Person

mammograms are only available on actual film, they will be digitized and sent back to your facility)

mammograms are only available on actual film, they will be digitized and sent back to your facility)

**Please check Images and/or Reports:
 IMAGES REPORTS**

 CT Ultrasound

 MRI X-Ray

 Mammograms – Please send last three exams

**Please check at least one:**

are only available on actual film, they will be digitized and sent back to your facility)

(If mammo’s are only available in original films, we will digitize them & send them back to your facility)

**Burn disk** or **Push to WMC PACS**

 ***If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and the parent or legal guardian must sign***

I understand that I may revoke this authorization at any time, except to the extent that action, based on this authorization, has already been taken. This consent will expire automatically six months from date on which it was signed. Any disclosure of medical record information or protected health information (PHI) by the recipient(s) is prohibited by law.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature of Other Authorized Person Date

I affirm that the patient is deceased, that no personal representative of his/her estate has been appointed, and that I am the patient’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date