PO Box 219 / 1400 Uinta Drive
Green River, WY 82935
Ph: 307-872-4500 Fax : 307-872-4595

AUTHORIZATION TO RELEASE / RECEIVE MEDICAL RECORDS

Date: ________________________________

REGARDING:
Patient Name: ___________________________________
Patient DOB: _____________________________________
Patient SSN (last 4): _______________________________
Patient Phone: ___________________________________

Records to be released from:	And given to:
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________

What information is needed?
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____
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The purpose of this release is to facilitate health care and treatment.

I understand that my records are protected under Federal Law Regulations and cannot be disclosed without my written consent or as otherwise permitted by such regulations. I understand that I may revoke my consent for disclosure in writing at any time, except to the extent that action has been taken. This authorization will remain in effect for one (1) year.

_______________________________________	_______________________________________
Patients Signature	Parent / Authorized Representative
_______________________________________	_______________________________________
Witness	If Representative, Relation to Patient

Castle Rock Medical Center

Medical Records Department

It is the policy of Castle Rock Medical Center to require a current specific authorization to release the types of information listed below. As a result, if such information is contained in the patient's records, that information will not be released to you at this time unless authorized below.

SPECIFIC AUTHORIZATION:	**INITIALS:**
Mental Health Information	________
Drug / Alcohol Information	________
AIDS/HIV Testing	________

The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease. 63 O.S. 1-502.2B

FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 41 CFR PART 2. GENERAL AUTHORIZATION FOR THE RELEASE OF INFORMATION OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. FEBERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.

I also understand that my consent for disclosure is subject to my written revocation.

I release Castle Rock Medical Center of any all claims and demands arising out of the release of the information to the above party named:

____	____
Patient Signature	Date
____	____
Parent / Authorized Representative	Witness Signature