CASTLE ROCK MEDICAL CENTER

PO Box 219 / 1400 Uinta Drive
Green River, WY 82935
Ph: 307-872-4596 Fax : 307-872-4595
Email: medical.records@crhd.org

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL RECORDS

Patient Name:_____Date of Birth:_____/_____/_____

Patient SSN (last 4):_____Phone: (_____) _____Cell Phone: (____) _____

I request my medical records be released from:

_____

_____

_____

And given to:

_____

_____

_____

I request the following protected health information (PHI) be released from my medical record(s): Please check all that apply or describe the information specifically:

____Medical Records ____Radiology Reports ____Lab Results ____Immunization Records

Other:_____

Specific Date(s):_____ If no dates are specified, the last two years will be released.

I authorize the release of information in my health record which may include information related to:

____Behavioral or Mental Health Issues ____Sexually Transmitted Diseases ____ AIDS or HIV
____Sexual Assault Reports ____Alcohol or Drug Treatment

Purpose for requesting information: (Please check one)

____Continuation of Care ____Transfer of Care ____ Moving ____Referral/Consult

Other_____

By signing this authorization, I understand that:

- This authorization will remain in effect for one (1) year and that I may revoke this authorization in writing at any time.
- I understand that I cannot revoke authorization for information that has already been released in response to this authorization.
- I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, that after it is disclosed, the information may not be protected by state or federal confidentiality rules.

_____ _____
Patients Signature Date Parent / Authorized Representative

_____ _____
Witness If Representative, Relation to Patient