ATTN: HIM Dept
777 Avenue H
Powell WY 82435
Phone: 307-754-2267
FAX: 307-754-1131

AUTHORIZATION FOR USE OR DISCOLSURE OF PROTECTED HEALTH INFORMATION

Authorization for: Copies of Medical Record Paper ☐ Electronic ☐
Other ☐ Inspect or Review Medical Record ☐

Patient Information

Patient Name: ______________________________________ Date of Birth: __________________
(Last Name) (First Name)

Street Address: ______________________________ City:__________________ State: ____ Zip: _________

Phone: __________________

Failure to provide all information may invalidate this authorization.
Please fill in all shaded sections below:

Release To / Request From

I authorize Powell Valley Healthcare to Release/ Request Medical Records

Release To: ☐
Request From: ☐
Person/Organization: __________________________________

Address: ____

City/State/Zip: _______________________________________

Phone: _____________________ Fax: ___________________

Reason for Disclosure

For the following:
☐ Continuing Care
☐ Insurance
☐ Legal
☐ Personal Use
☐ Other:
____

Information to Release

I request the following information to be released, which may include: alcohol and drug abuse/treatment; psychological and social work counseling; HIV or AIDS; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; genetic information and demographic information, for the purpose and conditions designated on this form.

Treatment Dates: _______________________________________

☐ History and Physical
☐ Emergency Record
☐ Lab Report
☐ Radiology/Xray Report
☐ Radiology/Xray Films/ Images/CD
☐ Outpatient/Clinic Record
☐ Other *(Please Specify)* __________________________
____
____

☐ Discharge Summary
☐ Operative Report
☐ Pathology Report
☐ Consultation Report
☐ EKG/Echo

PLEASE NOTE: DEPENDING ON VOLUME AND SIZE OF REQUEST, MEDICAL RECORD RELEASES MAY TAKE A WEEK OR MORE TO COMPLETE. ACCORDING TO WYOMING LAW, HEALTHCARE PROVIDERS ARE GRANTED 10 DAYS TO COMPLETE RELEASE OF INFORMATION REQUESTS.

Delivery Instructions

☐ Mail record copies directly to person or organization specified.

☐ Call requestor when record copies are ready for pick up.

☐Fax to the number above

☐ E-mail to the address below:

____

I authorize:

____
To pick up my medical record copies.
Relationship to Patient:
____

Please turn page over and complete this authorization by indicating the expiration date AND your signature

Notice of Rights	I understand that: 1. This authorization is voluntary. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment. 2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. 3. I may revoke or cancel this authorization at any time. Revocations must be made in writing and sent to Powell Valley Healthcare, Health Information Management Dept, 777 Avenue H, Powell, Wyoming 82435. Revocation/Cancellation will not and cannot apply to information already released. 4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior receiving the revocation. 5. I have a right to receive a copy of this authorization. 6. Once information has been disclosed, PVHC can no longer protect it from further disclosure.
Expiration	This authorization expires on: ________________________________ (*specify expiration date or event*). If left blank, the authorization will expire 12 months from the signature date below.
Payment	*Patients:* There is no charge to patients for a copy of their own records for their own files. *For all other parties:* The cost for release of record copies is $10 for the first 20 pages and $0.50/page for every page after 20. The record copies will not be released until payment is received. There will be additional fees associated with radiology requests that require a conversion of an original film which must be sent out for processing. The price for conversion is $10/film plus shipping and handling.

Signature	____Date:_________________ Signature of Patient or Legally Authorized Representative (*if patient is a minor or unable to sign*) ____ ___________________________ Printed Name of Legally Authorized Representative (*if patient is a minor or unable to sign*) — Relationship to Patient *(Parent, Guardian, Executor of Estate, etc.)*

Additional information Regarding your Request

Requesting medical records on behalf of another person: if you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record copies. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir at Law, Custody Papers, etc. Please contact the Health Information Management Dept to determine the documentation that will be required to process your request. *An official identification will be required to verify your identity*

HIM Staff Only	Type of ID checked: ☐ Driver's License *(attach copy)* ☐ Other ID ________________ Date checked:_________ Validated by: _________________ Number of pages released: _______ Request # _________

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