NIOBRARA COMMUNITY HOSPITAL &CLINIC
Medical Records Department
921 S Ballancee Ave/PO Box 780
Lusk, WY 82225
Phone: 307-334-400 | Fax: 307-334-2712

Authorization to Release Protected Health Information (PHI)

Patient Name (First, Middle, Last)	Date of Birth

RELEASE FROM	RELEASE TO
NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE:	PHONE:
FAX:	FAX:

Purpose of Release	Information to be Released
○ Treatment/Continuation of Care ○ Personal ○ Legal Purpose ○ Disability ○ Application of Insurance ○ Payment of Insurance Claim ○ Other	○ Entire Medical Record ○ Clinic Records ○ Hospital Records ○ Labs ○ Radiology Reports ○ Radiology Disk ○ Billing Records
Service Dates | From:	To:

I understand the information to be released my include records related to behavior and/or mental health, alcohol and drug abused treatment, HIV/AIDS and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization.

_____ I may be charged for copies of records in accordance with Wyoming State Law.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and my no longer be protected by law. This authorization will expire on year from the date signed unless I indicate an earlier date here:_____

ATTENTION: This is a legal document. Please read it carefully. By signing, you agree that you understand and accept the terms of this form.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18years of age or older, and is incapable of signing, a legal representative may sign and date the form
  - Legal Guardian or Conservator
  - Health Care Agent (Health Care Power of Attorney)
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date this form, unless an exception exists under state or federal law. Please include your relationship.
  - Parent
  - Legal Guardian

Signature:	Date Signed:
Printed name of person signing (if not patient)	

----------DISPOSITION OF RELEASE----------OFFICE USE ONLY----------

Faxed:_____ Mailed: _____ Patient Pick-up: _____ Staff Initials_____