

Western Medical Associates, PC.
6500 E 2nd St. Ste. 200 Casper, WY 82609
(307)577-5100 *phone* (307)234-1201 *fax*

Authorization for Disclosure of Protected Health Information

Patient Name: _____
Telephone #: _____
Date of Birth: _____
SSN#: _____

RELEASE FROM

RELEASE TO

WMA

- *Please check here if you are transferring primary care

*give complete information of where records are to be sent, including physician name, phone and fax number, and address if applicable. Failure to provide this information could result in a delay of processing.

Purpose of disclosure: _____

Information to be disclosed:

Dates(if applicable):

Entire record _____

Lab reports _____

Radiology reports _____

Other (specify) _____

Specific authorization to disclose sensitive records

I authorize the disclosure of these additionally protected records (please initial next to each):

Alcohol and/or substance abuse records _____

Mental Health records (depression/anxiety) _____

Other Mental Health/Psychiatric records _____

Sexually transmitted disease information _____

HIV/AIDS information _____

*Federal law prohibits the re-disclosure of this information without the express written permission of the person to whom it pertains.

(Signature)

(Name Printed)

(relation to patient/authority to act for patient)

(Date)

*HIPAA allows 30 (thirty) days for a provider to respond to your request for records. Western Medical Associates medical records policy calls for a standard 2 (two) week turn around on all records requests. In certain instances, there may be applicable fees for copying records, including postage. This medical release form is valid for above stated medical records for **1 (one) year** from signed date. Records **will not** be faxed to an unsecure fax line. I understand that I may revoke this authorization in writing at any time prior to Western Medical Associates, PC, acting upon the authorization. I understand that Western Medical Associates, PC, may not base treatment or payment upon completion of this form. I understand that disclosed information may be subject to re-disclosure by the recipient and may no longer be protected by federal law, if the recipient is not a "covered entity."