**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**

_____

_____

_____

_____

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

**RELEASE TO**

**WESTERN MEDICAL ASSOC.**
6500 E 2nd St. Ste. 200
Casper, WY 82609

**(**307)577-5100 *phone*
(307)234-1201 *fax*

**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."