



777 Avenue H - Powell, WY 82435 Phone (307) 754-2267 -- www.pvhc.org
Hospital Medical Records Fax: 307-754-1131 Powell Valley Clinic Fax: 307-754-7217

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Birth date: _____

Other Names Used: _____

I hereby authorize: (Facility and address releasing records)

To release to: (Address & Facility/Person receiving)

The following health information/medical records:

- Dictated Hospital reports Specific reports _____
 Lab Reports ER reports Immunization Records
 X-ray/Reports Home Health Reports Billing Records
 Clinic Office Notes Other _____

For the purpose of: Continuation of care my personal records Legal

Other-Specify _____

If indicated by my signature/initials, I specifically authorize the release of the following types of information.

_____ **Information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**

_____ **Information about behavioral or mental health services and/or treatment for alcohol and drug abuse.**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

This authorization will expire (insert date or event): _____

(If not specified, this authorization will expire one year from the date on which it was signed.)

Signature of Patient _____ Relationship _____
or Representative _____ to Patient _____

Date Signed _____ Witness _____

Office Use Only

Type of identification checked and date: _____ (attach copy)

MR#: _____

Records released by: _____ Date: _____