Sublette County Rural Health Care District

Pinedale Medical Clinic
PO Box 627 Pinedale WY 82941
307-367-4133 (ph)307-367-6636 (fax)

Marbleton-Big Piney Clinic
PO Box 787 Big Piney WY 83113
307-276-3306 (ph) 307-276-3024 (fax)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

*** * * ***

1. _____ _____
Name of Patient Birth Date

_____ _____
Mailing Address Phone Number

_____
City, State, Zip

2. AUTHORIZES:

_____
Name of Health Care Provider/Plan/Other

_____
Mailing Address

_____
City, State, Zip Code

_____
Phone/Fax

3. RELEASE PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Mailing Address

_____
City, State, Zip Code

_____
Phone/Fax

4. INFORMATION TO BE RELEASED:

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Immunizations
___ X-ray Reports
___ Laboratory Reports
____Any Services performed at SCRHCD, but ordered by a non-SCRHCD Provider
___ Allergy Records
___ Prescriptions
___ Billing and payment information
___ Past 5 Years Medical Records
___ Other (Specify):_____

5. RELEASE METHOD/FORMAT REQUEST: (Check One) ____ Paper ____CD/DVD

6. PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Legal Investigation or Action
___ Changing Physicians
___ Other (Specify):_____

Conditions of Authorization

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. **Without expressed written revocation, this consent expires after one year.**

7. Signature of Patient: _____ Date: _____
(If signed by person other than patient, state relationship and authority to do so.)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney for Healthcare ☐ Authorized Legal Representative