Pain Consultants of the Rockies & Pain Treatment Center of Wyoming
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, the undersigned, authorize Pain Consultants of the Rockies, PC and/or Pain Treatment Center of Wyoming, LLC, to release or receive my health information as noted below:

PATIENT INFORMATION:

FULL NAME: _____ OTHER NAMES USED: _____

DATE OF BIRTH: _______________ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

RELEASE INFORMATION: ☐ TO ☐ FROM SECTION MUST BE FILLED OUT COMPLETELY FOR REQUEST TO BE PROCESSED

NAME|FACILITY: Pain Consultants of the Rockies ATTENTION: Medical Records

ADDRESS: 4136 Laramie Street, Suite A PHONE: (307) 633-8100

CITY: CHEYENNE STATE: WY ZIP: 82001 FAX: (307) 633-8108

RELEASE INFORMATION: ☐ TO ☐ FROM

NAME|FACILITY: _____ ATTENTION: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ FAX: _____

REASON FOR REQUEST: _____

INFORMATION TO BE DISCLOSED: I authorize the release of the following health information:

☐ All of my health information that the provider ha, including information to any medical history, mental or physical condition and any treatment received.

☐ Only the following records or types of health information: _____

_____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information _____ (Patient or Legal Representative Initials).

TERM: I understand that this Authorization will remain in effect:

☐ From the of this Authorization until the _____ day of _____, 20_____.

☐ Until the Provider fulfills this request.

☐ Until the follow even occurs _____.

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- I can request a copy of this form after I sign and date it.
- Physicians generally must respond in a reasonable time, but no later than 30 days.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE