

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & INFORMATION

Name \_\_\_\_\_

Birth Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Request \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

I hereby authorize the release of medical information:

To / From	UNIVERSITY OF WYOMING Student Health Service Dept. 3068, 1000 E. University Ave. Laramie, WY 82071 Phone: 307 766-2130 Fax: 307 766-2711	To / From	_____ Name _____ Street _____ City, State, Zip _____ Phone Fax
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### Specific Information Needed:

Medical Notes  
 X-Ray Report (specify) \_\_\_\_\_  
 Lab Results  Specific date \_\_\_\_\_  
 All  
 Pap & Pelvic Records  Most Recent  
 All  
 Health History  
 Immunization Records  
 Psychology/Psychiatry notes summary  
 Complete Record  
 Other: (specify) \_\_\_\_\_

### Purpose for This Disclosure:

Continuing Medical Treatment  
 Insurance  
 Consultation  
 Attorney  
 Other: (specify) \_\_\_\_\_

I UNDERSTAND that I have the right to a copy of (for a fee) or to inspect the disclosed information if so requested. All medical records given to the patient will be copied at no charge the first time. For additional copies to the patient, charges will be assessed. Whenever records are given to insurance companies, attorneys, or any other authorized persons, charges will be assessed. Information released to the Student Health Service will not be further transferred from this facility. I UNDERSTAND this information may be faxed, hand-carried, or mailed, and persons other than those it is intended for may have access to it. I UNDERSTAND that Student Health Service will attempt to keep records confidential. This release expires six months from the date noted above, or earlier by written request. I have the right to revoke this request, if the revocation is submitted in writing. I HEREBY RELEASE THE ABOVE LISTED FACILITY, ITS EMPLOYEES, STAFF, AND AGENTS FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY MEDICAL RECORDS.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Patient or authorized person

### FOR STUDENT HEALTH SERVICE USE ONLY

Information to be:  Mailed  Picked-Up  Faxed  Other Date Needed: \_\_\_\_\_

Information sent by: \_\_\_\_\_ Date: \_\_\_\_\_  
Employee Name/Signature