

**JOHNSON COUNTY HEALTHCARE CENTER**  
PATIENT AUTHORIZATION TO **RELEASE and/or OBTAIN** HEALTH INFORMATION  
Johnson County Memorial Hospital, Family Medical Center, Amie Holt Care Center,  
Susie Bowling Lawrence Hospice and Johnson County Home Health  
497 West Lott, Buffalo, WY 82834

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Medical Record #: \_\_\_\_\_ SS #: \_\_\_\_\_ Email: \_\_\_\_\_

I authorize **Johnson County Healthcare Center** to  **RELEASE** /  **OBTAIN** medical information for the above-named individual's health information **to/from**:

Name (*Physician/Clinic/Hospital/Agency, etc.*): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Email: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

**Fax or Send to: \*\*If more than 20 pages, please mail records\*\***

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> <b>Johnson County Memorial</b><br>Ph: 307-684-6197<br>Fx: 307-684-6335 | <input type="checkbox"/> <b>Family Medical Center</b><br>Ph: 307-684-2228<br>Fx: 307-684-2177 | <input type="checkbox"/> <b>Amie Holt Care Center</b><br>Ph: 307-684-2122<br>Fx: 307-684-2149 | <input type="checkbox"/> <b>Home Health/Hospice</b><br>Ph: 307-684-6137<br>Fx: 307-684-6336 |
|---|---|---|---|

**\*\* All Health Information Management inquiries please fax request to 307-684-6335.**

**Information to be disclosed includes:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Laboratory Results               | <input type="checkbox"/> Scheduling/Cancelling appointments     |
| <input type="checkbox"/> Discharge Summary       | <input type="checkbox"/> Radiology Report                 | <input type="checkbox"/> School Physical                        |
| <input type="checkbox"/> Emergency Room Notes    | <input type="checkbox"/> Radiology Films                  | <input type="checkbox"/> Accompany to clinic visits (minor)     |
| <input type="checkbox"/> All Physician Notes     | <input type="checkbox"/> EKG                              | <input type="checkbox"/> Immunizations                          |
| <input type="checkbox"/> Physician Orders        | <input type="checkbox"/> Medication Administration Record | <input type="checkbox"/> Outside Facility Records (in JCHC EHR) |
| <input type="checkbox"/> ALL Communications      | <input type="checkbox"/> ALL Medical Records              | <input type="checkbox"/> Billing / Demographics                 |
| <input type="checkbox"/> Other: _____            |   |   |

Date(s) of service for records: \_\_\_\_\_

**Expiration Date:**  One-time release  1 year from date signed

I acknowledge that any outside facility medical records obtained did not originate from JCHC and may not be in complete form. \_\_\_\_\_ (*initial*).

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results and AIDS information \_\_\_\_\_ (*initial*).

**This information will be used for (Check One):**

- Continuing Care  Insurance purposes  Personal  Legal purposes  Viewing only

I understand my treatment, payment, or eligibility for benefits may not be conditioned on signing this authorization. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. **This authorization will automatically expire one (1) year from the date signed.** I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. To revoke this authorization, I must do so by submitting my request in writing to Johnson County Healthcare Center.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship to patient if signed by other than the patient Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

**Prior to release, one of the following must be provided:**

- Photo ID (valid Driver's License, stated ID, and or Passport)  
 Copy of photo ID, if requesting by mail or facsimile  
 Other verification: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

Faxed  Mailed  Email  In person Completed by: \_\_\_\_\_ Date: \_\_\_\_\_