JOHNSON COUNTY HEALTHCARE CENTER - 497 West Lott, Buffalo, WY 82834
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

Patient Name: _____ Date of Birth: _____

Address: _____

Medical Record #: _____ SS #: _____

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

Name (*Physician/Clinic/Hospital/Agency, etc*): _____

Address: _____ Phone: _____

City/State/Zip: _____ Fax: _____

Dates to be included in this release: _____ to _____

No date restriction **expires (1) year from date signed**, initial here: _____

Fax or Send to:

If more than 20 pages, please mail records

❒ Johnson County Healthcare Center
497 West Lott St
Buffalo, WY 82834
Phone: 307-684-5521
Fax: 307-684-6335

❒ Family Medical Center
497 West Lott St
Buffalo, WY 82834
Phone: 307-684-2228
Fax: 307-684-2177

Information to be disclosed includes:

❒ Discharge Summary
❒ History and Physical Exam
❒ Consultation Reports
❒ Physician Orders
❒ PT/ST/OT Reports
❒ Scheduling/Cancelling appointments
❒ Progress Notes
❒ Laboratory Results
❒ Physician Notes
❒ EKG
❒ Medication Administration Record
❒ Radiology Reports
❒ Radiology Films
❒ Verify Appointments
❒ School Physical
❒ Accompany to clinic visits (minors)
❒ Other: _____

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.

_____ Date: _____
Signature of Patient or Legal Representative

_____
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 ❒ In person Completed by: _____ Date: _____