Pinedale Medical Clinic
Sublette County Hospital District
PO Box 627, Pinedale, WY 82941
Phone: (307) 367-4133 Fax: (307) 367-6636

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
****

1. _____   _____
         Name of Patient   Birth Date

_____   _____
      Mailing Address   Phone Number

_____
         City, State, Zip

2. AUTHORIZES: **3. RELEASE PROTECTED HEALTH**
                                                    INFORMATION TO:

_____   _____
Name of Health Care Provider/Plan/Other   Name of Health Care Provider/Plan/Other

_____   _____
Mailing Address   Mailing Address

_____   _____
City, State, Zip Code   City, State, Zip Code

_____   _____
Phone/Fax   Phone/Fax

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

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

6. PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)
___ Further Medical Care   ___ Changing Physicians
___ Insurance Eligibility/Benefits ___ Other (Specify):_____
___ Legal Investigation or Action

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