



# Cheyenne Regional Medical Center

## Health Information Management (HIM) Instructions for Release of Health Information

1. Complete the Release of Health Information Form.
  - a. Please provide your contact information including telephone number in case we need to contact you.
  - b. Please initial below **Special Consent** only if you wish to release information pertaining to Drug and Alcohol Treatment, HIV/AIDS, or Behavioral Health. This is required only if you wish to release this type of information.
  - c. Please sign and date. If you are signing for a patient other than yourself, the HIM Department must have a valid copy of the appropriate government or court document, i.e. Power of Attorney, before any health information can be released.
2. Send the completed form, along with a legible copy of your valid government photo identification, i.e. Driver's License, Military I.D. to HIM for processing:

**Mail:** CRMC  
Attn: HIM Department  
214 East 23<sup>rd</sup> Street  
Cheyenne, WY 82001

**Phone:** (307) 634-2273

**FAX:** (307) 432-3108

3. Please note there is a 10 day waiting period once we have received your request. Also there may be a fee for a printed copy of your medical record. Please call for the current fee schedule and information.



# Cheyenne Regional Medical Center

## AUTHORIZATION for RELEASE of HEALTH INFORMATION

PLEASE provide a copy of photo identification

CRMC  
Attn: HIM Department  
214 East 23<sup>rd</sup> Street  
Cheyenne, WY 82001  
Phone: 307-634-2273  
Fax: 307-432-3108

Rec'd date/by: \_\_\_\_\_  
Pick up \_\_\_ Faxed \_\_\_ Mail \_\_\_  
Archived record ordered: \_\_\_\_\_  
Sent/by: \_\_\_\_\_  
Pgs: \_\_\_\_\_ Fee: \_\_\_\_\_  
MRN: \_\_\_\_\_  
Acct#: \_\_\_\_\_

**I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and is not a condition of treatment. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure, in which case it may no longer be protected by federal privacy regulations. (This form must be completed and signed before any health information can be released.)**

I have read and I understand the above paragraph. I hereby authorize \_\_\_\_\_

(Name and Address of Party Releasing Information)

or any of its employees, staff or agents, to **RELEASE CONFIDENTIAL INFORMATION** pertaining to:

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

DATE OF BIRTH: \_\_\_\_\_ DATE(S) OF TREATMENT to be released: \_\_\_\_\_

### Information to release:

- Face Sheet
- ER Dictation
- Discharge Summary
- History & Physical
- Treatment Reports  
(Includes Procedure/Operative reports, Consults, PT)
- Diagnostic Testing Reports  
(Includes Radiology, Lab, Cardiopulmonary, Cardiac)
- Complete Medical Record
- Physician order/progress note
- Nurses notes (includes all nursing/clinical entries)
- Medication Administration Record (MAR)
- Consents
- Information available on CD upon request

This information is to be released for the following purpose(s):  Continued Care  Attorney  Insurance  
 Other (Specify reason): \_\_\_\_\_

RELEASE INFORMATION TO: \_\_\_\_\_

(Street) (City, State, Zip Code) (Telephone #) (FAX # if known)

### Special Consent:

The following records **require special consent**. By placing my **initials** in the space provided, I **consent** to the release of the following health information regarding my treatment or hospitalization.

- \_\_\_\_\_ Drug and alcohol treatment care
- \_\_\_\_\_ Infection with Human Immunodeficiency Virus (HIV) Acquired Immunodeficiency Syndrome (AIDS)
- \_\_\_\_\_ Psychiatric care

This authorization to release health information may be revoked by me, in writing delivered to CRMC at the address above, at any time, except to the extent that action has already been taken in reliance on this authorization.

\_\_\_\_\_  
Patient Signature Date Expiration Date (expires one year from effective date if blank)

\_\_\_\_\_  
Signature of Personal Representative Description of Authority to Act on behalf of Patient Date  
*Other than parent of a minor child: COPY OF POA, COURT ORDER, OR LETTER OF TESTAMENTARY REQUIRED AT TIME OF REQUEST*



MRC Approved: 1/08/2010