Internal Medicine Group
2301 House Avenue, Suite 300
Cheyenne, WY 82001
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Form D

Authorization to Release Medical Information

Please print clearly

Internal Medicine Group, P.C. 2301 House Avenue, Suite 300 Cheyenne, WY 82001 307-635-4141 or 800-374-7687	Patient: _____ SSN: _____ Date of Birth: _____

I authorize Internal Medicine Group to discuss information associated with my medical care and treatment with *(ie: spouse, sibling, friend):*

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

INFORMATION TO BE SHARED *(Please check all that apply):*

- ❒ Admission history and physical
- ❒ Discharge Summary
- ❒ Complete hospital chart
- ❒ Office notes
- ❒ Lab Reports
- ❒ Radiological images
- ❒ Consultation notes or reports
- ❒ Outpatient records
- ❒ Psychiatric and other mental health records
- ❒ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me. (These records should be redacted to protect information pertaining to other patients.)

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

This authorization is valid and in force until revoked. I understand that I can revoke this authorization at any time by writing to the health care provider but revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Internal Medicine Group, P.C. may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as the original.

_____
Patient or Representative Signature Date

_____
Witness to Signature Date

_____
Name of Representative, if required (print)

_____
Relationship to Patient