Internal Medicine Group
2301 House Avenue, Suite 300
Cheyenne, WY 82001
Fax 307-638-2656 Phone 307-635-4141 www.imgwy.com

Form F

Authorization for Release of Protected Health Information

Section 1 Patient Information – PLEASE PRINT CLEARLY

Patient Name: _____ Gender: ☐ M or ☐ F

Date of Birth: _____/_____/_____ Last 4 Digits of Social Security Number: _____

Phone Number: (_____)_____-_____ E-mail: _____

Address: _____
Street *City* *State* *Zip*

Section 2 Information to be Released by: (Organization providing the information)

Organization's Name: _____

Address: _____

Phone: _____ Fax: _____

Section 3 Information to be Released to: (Organization receiving the information)

Organization's Name: _____

Address: _____

Phone: _____ Fax: _____

Section 4 Information Requested (Please be specific—type of information, date(s) of service, etc.)

The following individual identifiable health information should be disclosed:

Date(s)of Service: _____

❒ Lab(s) ❒ Office Notes ❒ Tests ❒ Medications ❒ Allergies

❒Other *(list):* _____

_____

_____

The information will be disclosed for the purpose of: ◯ Continuing Medical Care ◯ Attorney/Court Case

◯ Other (please specify): _____

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Section 5 Patient Authorization

This release will expire one year following the issuance of this request. I understand that this Authorization may be revoked by me at any time. I also understand that IMG will not withhold treatment if I do not sign this Authorization. I further understand that when my information is disclosed pursuant to this Authorization, re-disclosure by the recipient may no longer be protected by the federal HIPAA Privacy Rule.

Signature: _____ **Date:** _____

Relationship to Patient (if signing as legal guardian to patient): _____

This Authorization may be revoked by writing to: Medical Records Supervisor
Internal Medicine Group, P.C.
2301 House Avenue, Suite 300
Cheyenne, WY 82001

I specifically authorize the release of information relating to:

- Behavioral Health
- Substance abuse (including alcohol/drug use)
- HIV related information (AIDS related testing)

Signature: _____ Date: _____