HOT SPRINGS HEALTH
150 East Arapahoe Street | Thermopolis, WY 82443
307-864-3121 | Fax: 307-864-5007 | www.hotspringshealth.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City/State: _____ Zip Code: _____

RELEASE INFORMATION FROM: (PLEASE SPECIFY FACILITY)

☐ Hospital ☐ Riverton ☐ Shoshoni ☐ Thermopolis ☐ Worland

DELIVERY INFORMATION

☐ Mail ☐ Self-Pickup ☐ Email (address): _____

NOTE: There is a level of risk that a third party could access you Protected Health Information (PHI) without your consent when faxed or when electronic media is unencrypted. We are not responsible for unauthorized access to faxes, unencrypted media or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in any electronic format.

<table>
<tr><td>For the Dates of Service</td><td>From:</td><td>To:</td></tr>
<tr><td rowspan="3">Information to be Released</td><td colspan="2">☐ All Pertinent Records:
(includes Allergies, Laboratory, Consultation, Medication list, Discharge Summary, Operative Report, ER Report, Pathology Report, EKG Report, Problem List, History & Physical, Radiology Report)

☐ Entire Medical Record:
(includes full “designated record set” defined in 45 CFR 164.501)</td></tr>
<tr><td>Images/Photos: (Specify type of images/ photos i.e. X-Ray, CT, wound phone, etc.):
☐ Radiology Images (CD):
☐ Other images/photos:</td><td rowspan="2">Specific Documents/Notes:
☐ Clinic Visits/Notes
☐ Lab Reports
☐ Pathology Reports
☐ Radiology Reports
☐ Immunization Records</td></tr>
<tr><td>☐ Billing Records</td></tr>
<tr><td></td><td colspan="2">☐ Other: (please specify)</td></tr>
</table>

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, treatment of alcohol and/or drug abuse and genetic testing. My signature authorizes release of any such information. I understand that I may refuse to sign this authorization form. I understand that Hot Springs Health will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Hot Springs Health’s Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that I have a right to receive a copy of this authorization. This Authorization pertains to the information and dates specified on this Authorization. I understand that if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release Hot Springs Health, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient _____ Date _____

Relationship to Patient _____

Signature of Legal Representative _____ Date _____

FOR HEALTHCARE USE ONLY

Date Received: _____ Processing Staff: _____ ☐ ID/License Verified ☐ Verbal Release ☐ POA Verified

Additional Comments: _____

_____

Records picked up by: _____ Date: _____