AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & INFORMATION

Name _____

Birth Name _____ Date of Birth _____ Date of Request _____

Address _____ Phone _____

I hereby authorize the release of medical information:

To / From

UNIVERSITY OF WYOMING
Student Health Service
Dept. 3068, 1000 E. University Ave.
Laramie, WY 82071
Phone: 307 766-2130 Fax: 307 766-2711

To / From

_____
Name
_____
Street
_____
City, State, Zip

Phone Fax

Specific Information Needed:

_____Medical Notes
_____X-Ray Report (specify) _____
_____Lab Results ____ Specific date _____
____ All
_____Pap & Pelvic Records ____Most Recent
____All
_____Immunization Records
_____Psychology/Psychiatry notes summary
_____Complete Record
_____Other: (specify) _____

Purpose for This Disclosure:

_____Continuing Medical Treatment
_____Insurance
_____Consultation
_____Attorney
_____Other: (specify) _____

Requested records format:
_____Paper copy
_____Fax copy

I UNDERSTAND that I have the right to a copy of (for a fee) or to inspect the disclosed information if so requested. All medical records given to the patient will be copied at no charge the first time. For additional copies to the patient, charges will be assessed. Whenever records are given to insurance companies, attorneys, or any other authorized persons, charges will be assessed. Information released to the Student Health Service will not be further transferred from this facility. I UNDERSTAND this information may be COPIED TO PAPER OR DIGITAL MEDIA, faxed, hand-carried, or mailed, and persons other than those it is intended for may have access to it. I UNDERSTAND that Student Health Service will attempt to keep records confidential. This release expires six months from the date noted above, or earlier by written request. I have the right to revoke this request, if the revocation is submitted in writing. I HEREBY RELEASE AND HOLD HARMLESS THE UNIVERSITY OF WYOMING AND ITS PUBLIC EMPLOYEES FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY MEDICAL RECORDS.

SIGNATURE: _____ DATE: _____
Patient or authorized person

FOR STUDENT HEALTH SERVICE USE ONLY

Information to be: _____Mailed _____Picked-Up _____Faxed _____Other Date Needed: _____

Information sent by: _____ Date: _____
Employee Name/Signature

02/01/18