Star Valley Health
901 Adams Street | Afton, WY 83110
Phone: 307-885-5800 | Fax: 866-918-6774
www.starvalleyhealth.org

Authorization to Disclose Protected Health Information

Patient: _____ Date of Birth: _____

Address: _____

_____

Telephone: _____

Other names under which the patient has been treated: _____

I REQUEST and GIVE PERMISSION FOR Star Valley Health to disclose my records to:

_____

_____

Address City State Zip Code Phone

Disclose records via (circle one): Email _____ Fax_____ disc pick up mail

MY MEDICAL RECORDS/INFORMATION for care provided between (date) _____ and (date) _____

INFORMATION TO BE RELEASED: (check all that apply)

____ Clinic Records ____ History and Physical Exam ____ Laboratory Report ____ Radiology Report

____ Radiology Images ____ Operative/Consultation reports ____ Discharge Summary ____ Billing records

____ Other _____

FOR THE PURPOSE OF: (check one)

____ Patients request ____ Changing physician ____ Continuation of care

____ For potential pending legal proceeding ____ other: _____

Sensitive Nature Records: The individual signing this authorization expressly authorizes Star Valley Health to disclose information regarding drug, alcohol, or substance abuse, HIV/AIDS, sexually transmitted diseases, communicable diseases, behavioral health, (excluding psychotherapy) and genetic marker information.

I understand that: 1) I may refuse to sign this authorization and that it is strictly voluntary; 2) My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization; 3) I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices; 4) I understand that information disclosed by Star Valley Health pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations. 5) I understand that I may see and obtain a copy of the information described on this consent, for a reasonable copy fee, if I ask for it, and 6) I can get a copy of this form after I sign it.

This request will expire one (1) year from date of this release.

_____ _____ _____

Date Patient or patient's representative signature Print Patient or patients Representatives' name

_____

Relationship to patient