Casper Children's Center

AUTHORIZATION TO RELEASE/DISCLOSE MEDICAL RECORDS HIPAA COMPLIANT RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

FROM: Casper Children's Center, LLC
940 E. 3rd Street, Suite #205
Casper, WY 82601
Phone: 307 577 4260; Fax: 307 577 4263;
Email: info@casperchildrenscenter.com

Patient's Name: _____

Date of Birth: _____

I authorize and request Casper Children's Center to disclose my protected health information to the designated healthcare provider(s) listed below for the specified purpose:

_____

_____

I am authorizing release of all medical records pertaining to pediatric care and incidental findings care for the identified patient, above, including all full and complete protected medical information.

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes; inpatient, outpatient, and emergency room treatment; all clinical charts, reports, order sheets, progress notes, nurses' notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations; medication administration reports; documents, test

results, statements, questionnaires/histories; and records received by other medical providers.

☐ All physical, occupational, and other therapies' requests and related consultations.

☐ All laboratory, histology, cytology, pathology, immunohistochemistry records, and specimens reports; radiology records and images. .

I understand the medical records to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse, and/or mental health and psychiatric conditions and diagnoses. I have the option to refuse to release this type of medical information. I understand that if I check the "Yes" box below and add my initials, I am authorizing the release or disclosure of this type of information.

☐ Yes _____ (Initials) ☐ No

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. The healthcare providers who will receive this authorization are specified above.
b. By signing this authorization form, I am permitting the release of medical records from CCC.
c. I have a right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and present my written revocation to CCC and the health care providers who previously received my authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization.
d. My treatment or payment for my treatment will not be impacted by the signing of this authorization.

e. I will receive a copy of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize CCC to release the records requested herein as specified.

Casper Children's Center, LLC may charge a reasonable fee for copies of the medical record as stipulated in its professional fee schedule

_____

Printed Name of Patient

_____

Signature of Patient or Parent/Legal Guardian Date
(See 45CFR § 164.508(c)(1)(vi))

_____

Name and Relationship of Parent/Legal Guardian
(See 45CFR §164.508(c)(1)(iv))