Authorization to Release Protected Health Information (PHI)

Name *(First, Middle, Last)*	Date of Birth

Release Information From:	**Release Information To:**
◯ Cheyenne Urological, P.C. ◯ Other *(specify individual or facility, phone or fax if known)*	◯ Cheyenne Urological, P.C. ◯ Other *(specify individual or facility, phone or fax if known)* **Fax: 307-635-4134** Ph: 307-635-4131

Purpose of Release	**Information to be released**	
◯ Treatment/Continuation of care	◯ Clinic Notes	◯ Billing
◯ Personal	◯ Labs	◯ Consultations
◯ Legal Purpose	◯ Radiology	◯ Discharge Summary
◯ Disability	◯ Pathology/Cytology	◯ H&P
◯ Application for Insurance	◯ Operative reports	◯ Medications
◯ Payment of Insurance claim	◯ Hospital records	◯ In-office procedures
◯ Other	◯ Other	◯ Demographics

Service Dates From: To:	Information needed by:

I understand the information to be release may include records related to behavior and /or mental health, alcohol and drug abuse treatment, HIV/AIDSm and genetics. This authorization my be revoked at any time except to extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/ facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date signed unless I indicate an earlier date here: _____

ATTENTION: This is a legal document. Please read it carefully. By signing, you agree that you understand and accept the terms of this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older, and is incapable of signing,** a legal representative may sign and date the form.
  Please indicate your legal authority and include documentation of your relationship.
  ◯ Legal Guardian or Conservator ◯ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please include your relationship.
  ◯ Parent ◯ Legal Guardian

Signature *(Required)*	**Date Signed** *(Required) (month, day, year)*

Printed name of person signing *(If not patient)*

Mailing address of patient - *Street*			
City	State	Zip Code	Phone