Cheyenne Regional

Authorization to Disclose Health Information to Family or Other

STAMPER OR PATIENT LABEL

Patient's Name: ____ Date of Birth: ___________

Street Address: ____

City: ______________________ State: ______________ Zip: ___________

Home Phone: __________________________ Alternate Phone: ________________

I here by authorize Cheyenne Regional Medical Group to disclose health information to the following contact(s):

Contact #1

Name: ______________________________ Relationship to me: __________________

Street Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone: __________________________ Alternate Phone: ____________________

Contact #2

Name: ______________________________ Relationship to me: __________________

Street Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone: __________________________ Alternate Phone: ____________________

By signing this form I understand that Cheyenne Regional Medical Group may discuss past, present, or future health care issues with these contacts from ________________ through ________________

Start End

The information that may be disclosed or discussed is:

__________All my information (except HIV, mental health, and substance abuse)

__________HIV, mental health, and substance abuse information (please specify)

Signature: ____ Date: ______________

You may revoke this authorization at any time. Please note that cancellation by telephone must be confirmed in writing. However, your revocation will not affect any use or discloser that you permitted, and that was made prior to your revocation.

ROI

MRC Approved: grandfathered 2/2013

(2/2013, Epic 1/2014)