PERMISSION TO SEND HEALTH INFORMATION TO A WYOMING PAIN CLINIC, PC

Use this form when you want a health care provider to send your medical records to AWPC

dba/ Powder River Pain Clinic, Big Horn Pain Clinic and Platte River Pain Clinic

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

SENDER

I authorize:

Name of Provider: _____

Street Address: _____ Fax Number: _____

City: _____ State: _____ Zip: _____

RECIPIENT

to share (disclose) my health information with A Wyoming Pain Clinic at the following location

A Wyoming Pain Clinic, PC
3100 West Lakeway Rd, Ste 3
Gillette, WY 82718
Phone Number (307) 696-2996
Fax Number (307) 670-8250

If mailing my information, please return requested records to the office above

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ to _____

- ☐ Discharge Summary
- ☐ Emergency Department Reports
- ☐ Immunizations
- ☐ Inpatient Progress Notes
- ☐ Laboratory/Pathology Reports
- ☐ Operative Reports
- ☐ Outpatient Visit (Office) Notes
- ☐ School physical forms
- ☐ X-Ray Reports
- ☐ Other _____
- ☐ Records from a specific provider: _____

For the following purpose: _____

SENSITIVE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I undersand and agree that this information will be sent to A Wyoming Pain Clinic at location notes above UNLESS I place my initials in the applicable space next to the type of records:**

_____ Mental health treatment records
_____ Genetic Testing
_____ HIV/AIDS test results
_____ Sexually Transmitted (STD) treatment records
_____ Alcohol/Drug abuse treatment records

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Rep may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: A Wyoming Pain Clinic, PC and _____**(SENDER NAME)** will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protested under federal and state privacy regulations. Your sending health care provider may require fees to process your request.

SIGNATURE

_____ Signature of Patient or Personal Representative

_____ Date

_____ Printed Name of Patient or Personal Representative

_____ Description of Personal Representative's Authority

A Wyoming Pain Clinic, PC

Do Not Scan to AWPC Medical Record