7212 Commons Circle
Cheyenne, WY 82009

Phone: 307-635-4141
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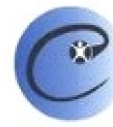
Wyoming Endoscopy Center
7220 Commons Circle
Cheyenne, WY 82009

Authorization to Release Medical Information

Patient:____

SSN:________________________________Date of Birth________________

I authorize Digestive Health Associates to discuss information associated with my medical care and treatment with (i.e. spouse, sibling, friend):

Name	**Relationship**
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

INFORMATION TO BE SHARED (please check all that apply):

- ◯ Admission history and physical
- ◯ Discharge Summary
- ◯ Complete hospital chart
- ◯ Lab Reports
- ◯ Psychiatric and other mental health records
- ◯ Medication administration logs, dietary logs, staff contact or service logs, and o other records that may not be part of my individual medical record, but which Contains information relating to me.
- ◯ Outpatient Records
- ◯ Office Notes
- ◯ Consultation notes or reports
- ◯ Radiological Reports

(These records should be redacted to protect information pertaining to other patients)
I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric care, and treatment of alcohol and /or drug abuse; my signature Authorizes release of any such information.

This authorization is valid and in force until revoked. I understand that I can revoke this authorization at any time by writing to the health care provider but revoking this authorization will not affect disclosures made or actions taken before revocation is received.

I also understand:

- I am not required to sign this authorization and that my health care or payment will not be Affected by my refusal
- Federal privacy regulations will no longer apply To the information disclosed, and that Digestive Health Associates may re-disclose the information
- I am entitled to receive a copy of this authorization
- A Copy of this authorization may be utilized with the Same effectiveness as the original

____
Patient or Representative Signature Date

____
Witness to Signature Date

____
Name of Representative, if required (print)

Relationship to patient____________________