DIGESTIVE HEALTH ASSOCIATES of Cheyenne
7212 Commons Circle
Cheyenne, WY 82009

Phone: 307-635-4141
Fax: 307-638-2656
www.dhawy.com

Wyoming Endoscopy Center
7220 Commons Circle
Cheyenne, WY 82009

Authorization for Release of Protected Health Information

Section 1 Patient Information - PLEASE PRINT CLEARLY

Patient Name:_____ Gender: F / M

Date of Birth_____/_____/_____ Last 4 digits of Social Security Number:_____

Phone Number:(_____)_____-_____ E-mail:_____

Address:_____
Street *City* *State* *Zip*

Section 2 Information to be Released by: (Organization providing the information)

Organization's Name_____

Address:_____

Phone:_____ Fax:_____

Section 3 Information to be released to: (Organization receiving information)

Organization's Name_____

Address:_____

Phone:_____ Fax:_____

Section 4 Information Requested (please be specific-type of information, date(s) of service, etc.)

The following individual identifiable health information should be disclosed:

Date(s) of Service:_____

◯ Lab (s) ◯ Office Notes ◯ Tests ◯ Medications ◯ Allergies

This information will be disclosed for the purpose of: ◯ Continuing Medical Care ◯ Attorney/Court Case

◯ Other (please specify):_____

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Section 5 Patient Authorization

This release will expire in one year following the issuance of this request. I understand that this authorization may be revoked by me at any time. I also understand that DHA will not withhold treatment if I do not sign this Authorization. I further understand that when my information is disclosed pursuant to this Authorization re-disclosure by the recipient may no longer be protected by the Federal HIPAA Privacy Rule.

Signature:_____**Date:**_____

Relationship to Patient (if signing as legal guardian to patient):_____

This Authorization may be revoked by writing to:

Medical Records Supervisor
Digestive Health Associates
7212 Commons Circle
Cheyenne, WY 82009

I specifically authorize the release of information relating to:

- Behavior Health
- Substance abuse (including alcohol/drug)
- HIV related information (AIDS related testing)

Signature:_____Date:_____