Authorization for Relase of Information

I, _____ DOB: _____

Currently living at _____
Street Address

_____
City State ZIP

( ) _____
Phone Number

Authorize _____ to release to:
Name and address of organization releasing information

Carol Fischer, MD 1331 Prairie Ave Ste 2, Cheyenne, WY 82009 tel: 307-778-3121 **fax: 307-637-1558**
Name and address of organization receiving information

_____

_____

Regarding the physician services of: _____

The information will be used for: ( ) Personal ( ) Insurance ( ) Other

( ) Continued care/consultation/2nd opinion ( ) Attorney

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or person listed above. Drug and alcohol abuse records are specifically protected by federal regulations and by signing this form I am allowing the release of any drug, alcohol and/or psychiatric information records to the agency listed above. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted diseases. By signing this authorization, I am allowing this information to be released to the agency or person specified above. I also understand that I may revoke this authorization at any time by written request from myself or my family except to the extent that action has already been taken in reliance upon it.

This consent shall remain in effect for ninety (90) from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent

I have read the above & foregoing authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Date: _____ Signature: _____

Date: _____ Signature: _____

The following applies only to drug/alcohol abuse or treatment information record: Prohibition of Re-disclosure. The information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose