Carol A. Fischer, MD PC
Kristi Roybal, FNP
Lana Sykes, FNP

1331 Prairie Avenue # 2, Cheyenne, WY 82009
Phone: 307-778-3121 **Fax: 307-637-1558**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Carol Fischer MD PC

Address: 1331 Prairie Ave, Suite 2

City: Cheyenne State: WY Zip Code: 82009

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Other: **Most recent labwork results, all diagnostic imaging and screening results, and most recent office visit note**

I understand that my medical records are confidential and by signing this authorization, I am allowing the release of my medical information to the requested agency or person as listed above.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.