Cheyenne OB&GYN
Kindness. Compassion. Experience you can trust.

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Authorization to Release Medical Records

I hereby request and authorize the use and/or disclosure of Medical Records:

☐ ALL medical records ***except*** sexually transmitted diseases (STD's) and psychological (mental health) records

☐ All medical records ***including*** sexually transmitted diseases (STD's), HIV, AIDS, ***and*** Psychological records

☐ Specific information: _____

Patient Full Legal Name:_____ Date of Birth:_____

Other Names Used:_____ SS Number:_____

Obtain Records From:

Name:_____

Address: _____

(Street) (City) (State) (ZIP)

Phone Number: _____ Fax Number: _____

Reason for Request of Records: _____

Disclose Records To:

Name:_____

Address:_____

(Street) (City) (State) (ZIP)

Phone Number:_____ Fax Number:_____

Please allow up to 2 weeks to process your records request. This request expires 12 months from the date signed.

Signature: _____ Date:_____

Witness: _____ Date:_____

All information released to or obtained from this facility will be used for the purpose of evaluation of medical status of this patient. Information released to us will not be further transferred from this facility without additional patient authorization. Authorization for the release of this patient's records may be withdrawn at any time. Please note: All medical records will be copied for the patient for free of charge the first time, however, a fee will be assessed accordingly for any additional copies.