Request to Release Information
Medical / Dental / Prescription Assistance Program

Patient Name: ______________________ DOB: ____________ PT#: ____________

Former Name(s): ______________________________ Phone: ____________

Patient Address: ____

I authorize: ____

To release the following information from my: ☐ Medical Record ☐ Dental Record and to send it to:

HealthWorks
2508 East Fox Farm
Cheyenne WY 82007
(307) 635-3618
Fax: (307) 635-1442

Information requested to be released for treatment dates: ____________________

☐ Progress Notes ☐ Laboratory Reports ☐ X-ray Reports ☐ Other: ____________________

For the purpose of:

☐ Further Treatment ☐ Insurance Claim ☐ Worker's Compensation

☐ Legal Request ☐ Transferring Care ☐ Other: ____________________

This consent for release of confidential information expires in 60 days. I understand I may review my medical records upon request, and I may revoke this authorization at any time, except to the extent that action has already been taken in compliance with this consent. This facility, its employees, and the attending physician are hereby released from legal responsibility or liability for the release of the above information.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

I acknowledge that information to be released MAY INCLUDE material that is protected by Federal Law. My initials on each blank and my signature below authorizes release of information.

If you DO NOT initial each blank, a document with that information will NOT be included.

Drug Abuse: ________ **HIV/AIDS:** ________ **Mental Health:** ________ **Alcohol Abuse:** ________

By signing this form, you authorize the Prescription Assistance Program to sign any and all forms – related to applications for manufacturer assistance programs - on your behalf and to access and release any personal demographics, diagnostic, therapeutic and/or financial information required

Signature: ______________________________ Date: ____________

Patient (or individual with durable power of attorney)