



**REQUEST TO SEND INFORMATION
MEDICAL / DENTAL / PRESCRIPTION ASSISTANCE PROGRAM**

Patient Name: _____ DOB: _____ PT#: _____

Former Name(s): _____ Phone: _____

Patient Address: _____

I authorize: HealthWorks (formerly Cheyenne Health & Wellness Center)

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

Name: _____

Company/Practice Name: _____

Address: _____

City / State / Zip: _____

Phone Number: _____

Fax Number: _____

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)