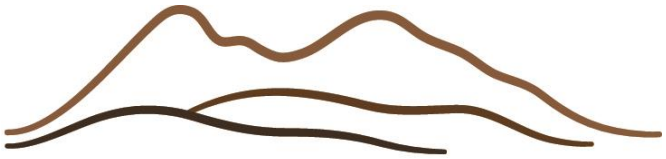

Snowy Range Health Center

Wendy King, FNP, PMHNP

2523 E. Garfield Suite B
PO Box 1126
Laramie, WY 82073-1126
P: 307.460.9888
F: 307.460.9892

I, _____do hereby consent to the release of any and all personal and confidential medical records.

Patient Name: _____ Previous or Maiden Name: _____

DOB: _____ Social Security Number: _____

Current Address: _____

Previous Address: _____

Home Phone: _____ Cell Phone: _____

FROM:

_____
Physician or Office Name

_____
Address

_____
City/State/Zip

_____/_____
Phone #/Fax #

Please include any or all of the following:
__Provider Notes
__Correspondences
__Hospital Notes
__Lab Work
__X-Rays/Results
__Diagnostic Test Results
__Mental Health Records
__Medication List
__Vaccination Records
__Other_____
__**Complete Medical Records**

TO:

_____
Physician or Office Name

_____
Address

_____
City/State/Zip

_____/_____
Phone #/Fax #

Purpose or need for release:
__ Transfer of medical care
__ Insurance
__ Legal
__ Patient's own use
__ Other _____

I understand this authorization is effective immediately and remains in effect until one year from the date signed. This release may be revoked in writing at any time. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. I have the right to revoke this authorization by written notice to the healthcare provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, AIDS or AIDS related complex and/or HIV.
Fee Note: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

_____ _____ _____
Signature Relationship Date