Babson & Associates Primary Care, P.C.

1331 Prairie Ave. Ste. 1 **Phone: 307 632-0728**
Cheyenne, WY 82009- 4867 **Fax: 307 632-5268**

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and is not a condition of treatment. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure, in which case it may no longer be protected by federal privacy regulations.

Patient Name: _____

Social Security Number: ___-___-_____

Date of Birth: _____

- ☐ Release Records To (Complete name and address):
- ☐ Obtain Records From (Complete name and address):

_____
_____
_____

Information requested: _____
_____
_____

I authorize Babson & Associates to release information regarding the following conditions (if applicable):

- ☐ Drug Abuse
- ☐ Alcoholism/Alcohol abuse
- ☐ Testing for or infection with HIV or other social diseases
- ☐ Sickle Cell anemia

Purpose/need for the above release of records:

_____
_____

I authorize the release of the above described records:

_____	_____	_____
Signature of Patient or Authorized Person	Date Signed	Expiration Date (If left blank, expires 2 years from effective date)

This authorization to release health information may be revoked by me, in writing delivered to the address above, at any time, except to the extent that action has already been take in relation to this authorization. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.