Authorization Form for the Release of Information

I hereby authorize my physician(s), health care provider(s), pharmacist(s), case manager(s), and all other individuals and agencies involved in my health care to release and exchange information with the Wyoming Department of Health and with the EIS contracted physicians concerning my diagnosis, treatment, findings, test results, opinions, and all other related and relevant information. I understand that this release will remain in effect for the period of time listed below or until such time as I revoke it, in writing, which I am free to do at any time. Photocopies of this release and authorization will be given the same effect as the signed original

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

I authorize the release of this information to the person named above for the following period of time:

From: _____ To: _____

Please retain this Authorization Form for Release of Information in your files for future inquiries from the person named above.

Client Information

_____ _____
Name (please print) Soundex #

_____
Address

_____
City/State/Zip Code

_____ _____
Signature of Client Date

Please return this form to:

_____
_____
_____
_____

Preventive Health and Safety Section
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