NORTHERN WYOMING Surgical Center

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization of voluntary. In doing so, I release Northern Wyoming Surgical Center, LLC, ("NWSC") from all liability once the medical records have been sent to parties identified below. I understand that if my health information is used or disclosed, the released information may no longer be protected by federal privacy regulations.

Patient Name:	**Date of Birth:**
Persons authorized to use the information:	**Persons authorized to use the information:**
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Specific description of information (including dates):

The patient or the patient's representative must read and initial the following statements:	**Initial**
I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.	
I understand that I may see and copy the information described on this form if I ask for it, and that NWSC will provide a copy of this form after I signed it.	
I understand that this authorization will expire on: _____/_____/_____.	
I understand that I may revoke this authorization at any time by notifying NWSC in writing. If I do revoke it, the revocation will **not** have any effect on any actions that NWSC took before it received before it received the revocation.	
According to law, there can be a processing fee for this transaction. The fee for this request is $_____.00	

Signature of Patient or Patient's Representative **Date**

Printed Name of Patient's Representative:

Relationship to Patient:

Northern Wyoming Surgical Center, LLC to complete the following:
What is the purpose of the use or disclosure?
Will NWSC receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes: No:

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