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: Debi Anderson or Toni Reeves

Address: 6101 Yellowstone Rd, Suite 510

City, State, Zip: Cheyenne, WY 82002

Phone Number: 307.777.5856 or 307.777.5800

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

From: 04/1/2012 To: 03/31/2013

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:
Wyoming Department of Health
6101 Yellowstone Rd, Suite 510
Cheyenne, WY 82002
Fax: 307.777.7382