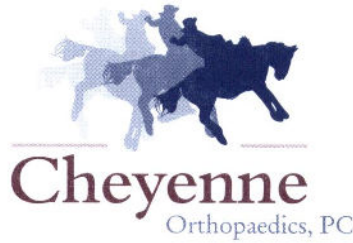


2301 House Avenue, Suite 505
Cheyenne, WY 82001
(307) 632-9261 • Fax: (307) 634-9170



Jean D. Basta, M.D.
Mark R. Rangitsch, M.D.
Richard E. Torkelson, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by the federal privacy regulations.

Patient Name: _____ **Date of Birth:** _____

Person/Organizations providing the information: _____ **Person/Organization receiving the information:** _____

Type of information disclosed: (Please mark)

___ Medical Records
___ X-Rays
___ Other _____

Purpose of disclosure: (Please mark)

___ Continuing Medical Care
___ Transfer of Medical Care
___ Attorney/Court Case
___ Insurance
___ Workers' Compensation Case
___ Personal Reasons
___ Other _____

This authorization will expire on: _____
(Date)

I understand that this authorization will expire one year from the date signed unless a specific date is listed above. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.

(Signature of Patient or Patient Representative)

(Date)

Printed name of Patient Representative _____

Relationship to the Patient: _____