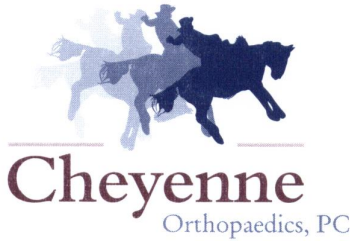


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## AUTHORIZATION FOR RELEASE OF INFORMATION

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: \_\_\_\_\_