DTC
DOWNTOWN CLINIC
serving Albany County

Medical Record Release

611 S. 2nd Street, Laramie, WY 82070 | Phone: 307-745-8445 | Fax: 307-745-8149

Patient Information

Client Name: _____ **DOB**: _____ **Phone:** _____

Address: _____**City:** _____**Zip:**_____

I authorize the Downtown Clinic to: ☐ **Release to** ☐ **Receive from**

- ☐ **Albany Community Health Clinic |1174 N. 22nd St | Laramie, WY, 82072 | 307-766-3313 (p) |307-766-3316 (f)**
- ☐ **Volunteers of America of NR | 1263 N 15th St | Laramie, WY, 82072 | 307-745-8915 (p) 307 -426- 4686(f)**
- ☐ **Ivinson Medical Group 255 N 30th Street | Laramie, WY | 82072 | 307.755.4540 (p) | 307-755-4539 (f)**
- ☐ **Other:**

_____ Name of facility/provider

_____ Address, City, State, Zip

_____ Phone number of facility/provider

_____ Fax number of facility/provider

_____ **(Initial) I authorize the ongoing exchange of information between the above organizations 1 year from the date of signature unless another date is specified:** _____

Records to Be Released

Timeframe to be released

Date(s)_____or number of Year(s) prior_____

Documents/Notes (check all that apply)

_____ Visit Notes _____Immunization Records _____Laboratory Reports

_____ Pathology Reports _____Imaging Reports _____ Other (Please Specify):_____

Protected and Sensitive Information Disclosure:

Additional laws relating to the use and disclosure of sensitive information may apply. By initialing, I understand and agree to release any sensitive information, pertaining to the following types of records or information.

_____ STD Information (Including HIV/AIDS) _____ Drug/Alcohol Related Information

_____ Mental Health Information _____ Genetic Testing Information

_____ All Records (including Protected and Sensitive Information)

Acknowledgments of Rights

I understand this authorization may be revoked at any time, but may not be revoked retroactively once records have been released.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name: _____ Relationship to patient (if applicable):_____