

### Disclosure of Cheyenne Regional Medical Center Laboratory

I hereby acknowledge the possibility of outside charges from the Cheyenne Regional Medical Center Laboratory has been disclosed to me. I understand lab billing inquires should be addressed with Cheyenne Regional Medical Center.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Printed Name / Relationship to Patient

\_\_\_\_\_  
Date

### Acknowledgement of receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a Notice of Privacy Practices of America's Express Urgent Care, LLC. I understand that my Protected Health Information (PHI) may be used and disclosed for the purposes of Treatment, Payment, and Healthcare Operations of the practices.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Printed Name / Relationship to Patient

\_\_\_\_\_  
Date

### Authorization for Release of PHI

I hereby authorize America's Express Urgent Care, LLC to release my Protected Health Information to/from the following:

Please fax requested records to (307) 426-4061

Name of Physician/Group:		
Address:		Phone #
City:	State:	Zip:
		Fax #

Other Person:		Relationship:
Address		Phone
City:	State:	Zip:
		Fax #

Should I wish to revoke this authorization for release I understand that I must do so in writing.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Printed Name / Relationship to Patient

\_\_\_\_\_  
Date