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 _____