The Lander Medical Clinic, PC is committed to protect your health information. In order to insure we will not withhold information from those you have authorized to obtain information on your behalf, those who request the information in person will be required to provide a picture identification to ensure identity. Please understand we are required by Federal law to protect your health information and these procedures will be enforced by our staff.

Patient Name (Please Print): ____

Date of Birth: ____

Person(s) authorized to obtain health information	Relationship to patient
1. ______________________________	____________________
2. ______________________________	____________________
3. ______________________________	____________________
4. ______________________________	____________________
5. ______________________________	____________________

By signing this form it is understood that **only** those named above are able to receive information regarding my case. Information they may possibly receive, but are not limited to include: Test results, appointment date and time information, direct visit information, billing information, and any other information that may otherwise be protected by the Privacy Policy that I have received and read.

______________________________ ____________________

Patient's Signature Date

______________________________ ____________________

Witness's Signature Date

I hereby grant permission for Lander Medical Clinic, PC to leave a message on/with (Please Check One)

☐ Home Phone ☐ Cell Phone ☐ Spouse ☐ Family Member

745 Buena Vista Drive ~ Lander, Wyoming 82520 ~ 307-332-2941