Medical Records Releasing TO Big Horn Bone and Joint

HIPAA Authorization for Use and Disclosure of Protected Health Information

Patient Name:

DOB: **Phone Number:**

I hereby authorize ________________________________to use and/or disclose the protected health information about me described below ("**PHI**") to **__Big Horn Basin Bone and Joint_______**.

The PHI that may be used and/or disclosed is: ____.

The PHI may be used and/or disclosed for the following purpose: ____.

This authorization shall remain in effect until: ________________________.

I understand that my treatment will not be conditioned on whether I sign this form.

I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that Big Horn Basin Bone & Joint has acted in reliance upon it, by sending written notification to: 720 Lindsay Lane, Suite C, Cody, WY 82414

I understand that I have the right to refuse to sign this authorization.

I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

Patient Name Date

________________________ ________________________

Patient Signature Relationship to Patient

________________________ ________________________

Please mail records to
Big Horn Basin Bone & Joint
Attn: Meggin Becker
720 Lindsay Lane, Suite C
Cody WY 82414
Or Fax to 307-578-1996 Phone # is 307-578-1955

Records Received Date: By: