Medical Records Releasing FROM Big Horn Bone and Joint
HIPAA Authorization for Use and Disclosure of Protected Health Information

Patient Name:

DOB: **Phone Number:**

I hereby authorize **Big Horn Basin Bone & Joint** to use and/or disclose the protected health information about me described below ("**PHI**") to _____ _____.

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
_____	_____

Records Sent/Faxed Date: By:
Information sent was: