BIGHORN MEDICAL CENTER
ORTHOPAEDIC & GENERAL SURGERY • SPORTS MEDICINE
JOINT REPLACEMENT • NEUROSURGERY • INTERNAL MEDICINE

PHI Use and Disclosure Authorization

3030 Big Horn Ave, Cody, WY 82414 307-578-1955 307-578-1996(f)

DATE: _____

First Name of Patient : _____ Last Name: _____ DOB:_____

Phone Number: _____ Address:_____

I authorize (Clinic or Doctor) to release the following health information:

Name, Address/ Phone number: _____

Name, Address/ Phone number: _____

Release and disclose the following records and Information:
_____Medical Records _____Images and Reports _____Lab Reports _____Billing Records
Other (be specific; i.e., body part, time frame, etc.):
_____
_____
_____

Purpose of Disclosure: ☐At request of pt. ☐Continuing Care ☐Personal Records ☐Legal ☐Insurance ☐Other
Release of the following information requires specific authorization. Initial by those that apply:
___HIV / AID testing / Treatment Records
___Drug, Alcohol or Substance Abuse Records
___Mental Health Records (excludes psychotherapy)
___Genetic Markers
Name of Entity or Person(s) to Receive Information:
Big Horn Medical Center 3030 Big Horn Ave. Cody, WY 82414 307-578-1955/307-578-1996(f)

Name, Address/ Phone number: _____

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to**:**
Big Horn Medical Center, 3030 Big Horn Ave Cody WY 82414. FAX to 307-578-1996.
I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.
I understand that this authorization is effective 12 months from signature date unless a different expiration date is provided ____/___ /_____ (specify new date)
I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.
Name of patient or Personal Representative (Type/Print): _____

Signature of Patient or Personal Representative: **_____**

Relationship to Patient: _____ Date: _____ HIPAA Privacy Rule Revised: 02/03/2016