Dr. Poffenbarger- Neurosurgery

1728 8th St. Cody, WY 82414 307-578-1955(p) 307-578-1996(f)

DATE: _____ First Name : _____ Last Name: _____

DOB:_____ Phone Number: _____

Address:_____

I authorize: Big Horn Medical Center 1728 8th St. Cody, WY 82414 To release and disclose the following records and Information: _____Medical Records _____Images and Reports _____Billing Records Other (be specific; i.e., body part, time frame, etc.):

_____

_____

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: Name, Address/ Phone number:

_____

_____

Please indicate you how you would like to receive information: _____ Fax _____ Call to Pick Up _____Fax Records and Mail Disc images ** We are unable to email records at this time**

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, 1728 8Th St, 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: _____