



# Casper Orthopaedics

Sports, Spine, Bones, Joints & Trauma

4140 Centennial Hills Blvd., Suite A • Casper, WY 82609

PHONE (307) 265-7205 • FAX (307) 235-6262  
1-888-317-2343

Medical Records   
Disabilities

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Patient Address: (Street, City, State, Zip Code)

\_\_\_\_\_  
Telephone Number

### RELEASE FROM:

\_\_\_\_\_  
Casper Orthopaedic Associates

\_\_\_\_\_  
Name of person, company or organization

\_\_\_\_\_  
4140 Centennial Hills Blvd.

\_\_\_\_\_  
Address

\_\_\_\_\_  
Casper, WY 82609

\_\_\_\_\_  
City, State, Zip Code

### RELEASE TO:

\_\_\_\_\_  
Name of person, company or organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

The following information is to be disclosed: (please check)

\_\_\_\_ Progress Notes

\_\_\_\_ Lab reports

\_\_\_\_ X-ray Reports\*\*

\_\_\_\_ Operative reports

\_\_\_\_ Pathology Reports

\_\_\_\_ X-ray films\*\*

\_\_\_\_ Other (please specify) \_\_\_\_\_

\*\*May only release images taken at Casper Orthopaedics

Please specify body part: \_\_\_\_\_

For health services provided on (dates): \_\_\_\_\_

Purpose for this request: \_\_\_\_\_

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

**Expiration:** This authorization expires one year from the signature date.

**Other Rights:** I understand that I may inspect or obtain a copy of the information to be used or disclosed.

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. If I have questions about disclosure of my health information, I can contact Casper Orthopaedic Associates at 307-265-7205.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Legal Representative's Address (Street, City, State, Zip Code)

**FOR MEDICAL RECORDS STAFF ONLY**

Release Date: \_\_\_\_\_ By \_\_\_\_\_

Delivery Type \_\_\_\_\_

*A copy of this authorization shall be considered as valid as the original*

*forms/frontoffice/release-mt*