Founder of

BIG HORN BASIN ORTHOPAEDIC CLINIC, P.C.

Founder of

YELLOWSTONE SPORTS MEDICINE L.L.C.

JIMMIE G. BILES, JR., M.D.
Diplomate of American Board of Orthopaedic Surgery

Sports Medicine • Orthopaedic Surgery • Joint Replacement • Arthroscopic Surgery

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name:________________________ Birth Date:____________ MR#:___________
Other Names Used: ____
I hereby authorize: (Facility and address releasing records)
____
To release to: (Address & Facility/Person receiving)
____

The following health information/medical records:

- ◻ Clinic Notes
- ◻ ER reports
- ◻ Billing Records
- ◻ Lab Reports
- ◻ Op-Notes
- ◻ Prescription Notes
- ◻ X-ray/Reports
- ◻ Other________________________________

For the purpose of: ◻ Continuation of care ◻ My personal records ◻ Legal
◻ Other – Specify ____
____

If indicated by my signature/initials, I specifically authorize the release of the following types of information.

__________ Information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

__________ Information about behavioral or medical services and/or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Yellowstone Sports Medicine. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

This authorization will expire (insert date or event):______________________________
(If not specified, this authorization will expire one year from the date on which it was signed.)

Signature of Patient or Representative ______________________________

Relationship to Patient ______________________________

Date signed: ______________________

Witness______________________________

Type of identification checked and date:______________________ (attach copy)
Records released by: ______________________________ Date: ____________

720 LINDSAY LANE • CODY, WYOMING 82414-4103 • 307-578-1953 • 877-372-4537

All authorizations for release of information will be reviewed against the following list of required elements. If any element is missing or not completed, we are unable to fill the request.

- ► The authorization may not be combined with any other document such as contest for treatment.
- ► The authorization must contain all of the H IPAA required "Core Elements"

  - A specific description of the information to be used or disclosed.
  - The name or identification of the person(s) or class of person(s) authorized to make the disclosure.
  - The name of identification of the Persons (or class of persons) authorized to make the disclosure.
  - A description of each purpose for the requested disclosure. If the patient requests the disclosure a statement that the disclosure is "at the request of the patient" is sufficient.
  - An expiration date or event that relates to the patient or the purpose of the disclosure, i.e. "until claim is settled" or "1 year from date of signature.
  - The date and signature of the patient or the patient's personal representative.
  - If the authorization is signed by the personal representative a description of the personal representative's authority, i.e. "Mother" or "Power of Attorney".
  - The right to REVOKE the authorization at any time in writing by submitting a written request to the covered entity.
  - A statement about whether or not treatment is conditioned on getting a signature.
  - Notice that the information disclosed, per the authorization, may be subject to re-disclosure and no longer protected.

- ► All of the foregoing must be COMPLETELY filled out. No blanks concerning the required terms are allowed.

- ► If you are requesting the authorization from the patient you must give the patient a copy of the authorization. You must also retain a copy of the authorization.