

# Wyoming Orthopedics & Spine

## Limited Patient Authorization for Disclosure of Protected Health Information.

Please print all information. Form must be signed and dated.

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Entity Requested to Release Information:** \_\_\_\_\_

Who will be authorized to receive information – I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below:

Individual/Entity Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax\*: \_\_\_\_\_ / \_\_\_\_\_

Email\*: \_\_\_\_\_

Please specify the format in which you would like the copies of PHI provided to you, or your designated recipient. We will accommodate your request, if possible.

- Paper copy  
 Electronic copy-preferred format: \_\_\_\_\_

**\*Secure Communication** – Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not include a recipient fax number or email address if this is a concern to you.

**Description of information to be disclosed** – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:

- |   |  |
|---|--|
| <input type="checkbox"/> office notes                   | <input type="checkbox"/> other physicians records              |
| <input type="checkbox"/> operative reports              | <input type="checkbox"/> physical therapy, home health/hospice |
| <input type="checkbox"/> lab results, pathology reports | <input type="checkbox"/> only disclose the following: _____    |
| <input type="checkbox"/> radiology reports              | <input type="checkbox"/> specific dates requested: _____       |
| <input type="checkbox"/> financial history              | <input type="checkbox"/> body part: right / left: _____        |

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

- Patient Request       Other (please specify): \_\_\_\_\_

This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: \_\_\_\_\_

You have the right to terminate this authorization at any time by submitting a written request to our office. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

\_\_\_\_\_  
patient or authorized representative signature

\_\_\_\_\_  
date

You have the right to receive a copy of signed authorizations upon request.