Closed address:
Ravalli Orthopedics & Sports Medicine, P.C.
312 Fairgrounds Rd.
Hamilton, MT 59840
406-361-7680

Current mailing address:
Ravalli Orthopedics & Sports Medicine
P. O. Box 1270
Cody, WY 82414

Authorization to Disclose Protected Health Information

This for is for all records requests

This will authorize release of information from:
Ravalli Orthopedics & Sports Medicine, P.C.

Release information to:
Name: _____
Address: _____
_____
_____

By signing this Authorization, I authorize release of my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE:

PATIENT'S FULL NAME _____

MAIDEN OR OTHER NAME _____

DATE OF BIRTH ____/_____/_____ **SOCIAL SECURITY NUMBER _____**

ADDRESS _____

Street, City, Zip, Phone number, cell if different

_____

Covering the period of health care:

FROM (Date) _____/_____/_____ **TO** (Date) _____/_____/_____

1. **Information authorized for disclosure,** *if included in my records:* check all that apply

- ☐ Appointment records
- ☐ Operative reports and discharge summaries
- ☐ Consultation documentation
- ☐ X-rays taken at Ravalli Orthopedics & Sports Medicine
  - *X-rays will be emailed to you*. Please provide email address:
    _____
- ☐ Intraoperative photographs
- ☐ Pathology reports

- ☐ Laboratory reports of those tests ordered by Ravalli Orthopedics & Sports Medicine
- ☐ Other *(please specify)* _____

2. **The purpose for which the disclosure is authorized** *(please specify)*

   _____

3. **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 Ravalli Orthopedics & Sports Medicine, P.C. **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 tight to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date: ___/___/_____ or the following condition(s): _____
   _____
   If I fail to specify an expiration date or condition, this authorization will expire in 90 days.
4. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.
5. Ravalli Orthopedics & Sports Medicine, P.C., its employees, officers, Physician's Assistant, and Physician are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated herein.

Printed name – (patient, parent, legal guardian, legal representative)

_____

Relationship if not patient

Signature date: MM/DD/YYYY