Thunder Basin Orthopaedics and Sports Medicine
808 Riverbend Drive, PO Box 688
Douglas, Wyoming 82633
307-358-6200(P), 307-358-3748(Fax)

Authorization to Release Medical Records

Date:_____

Patient Name:_____ DOB:_____

Recipient:

Name:_____
Mailing address:_____
City/State/Zip Code:_____
Phone Number:_____ Fax Number:_____

From:

Name:_____
Mailing address:_____
City/State/Zip Code:_____
Phone Number:_____ Fax Number:_____

Records to be release:

- ☐ Entire Medical Record
- ☐ Specific Medical Information
  - ☐ Records relating to a specific condition:_____
  - ☐ X-Ray reports regarding:_____
  - ☐ Lab results regarding:_____
  - ☐ Operative reports regarding:_____
  - ☐ Other:_____

Purpose for this release:

_____
_____
_____

I, _____, authorize the release of my health information. I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so in writing. I fully understand and accept the terms of this authorization.

This authorization shall expire on _____ or within one year of the date signed. After this date, ThunderBasin Orthopaedics can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

Signature Relationship to patient Date