2301 House Avenue,Suite 505
Cheyenne, WY 82001
(307) 632-9261 • Fax: (307) 634-9170

Cheyenne
Orthopaedics, PC

Jean D. Basta, M.D.
Mark R. Rangitsch, M.D.
Richard E. Torkelson, M.D.

# AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use and disclosure of my individually identifiable 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 the federal privacy regulations.

**Patient Name**: _____ **Date of Birth**: _____

**Person/Organizations providing the information**:

_____

_____

_____

**Person/Organization receiving the information:**

_____

_____

_____

**Type of information disclosed:** (Please mark)

____ Medical Records

____ X-Rays

____ Other _____
_____
_____

**Purpose of disclosure:** (Please mark)

____ Continuing Medical Care
____ Transfer of Medical Care
____ Attorney/Court Case
____ Insurance
____ Workers' Compensation Case
____ Personal Reasons
____ Other _____

This authorization will expire on: _____
(Date)

I understand that this authorization will expire one year from the date signed unless a specific date is listed above. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.

_____ _____
(Signature of Patient or Patient Representative) (Date)

Printed name of Patient Representative _____

Relationship to the Patient: _____