PREMIER BONE & JOINT CENTERS

A Registered Trade Name of Gem City Bone & Joint, P.C.

1909 Vista Drive
Laramie, WY 82070
Phone (307) 745-8851
Fax (307) 742-5607
Toll free 1-800-446-5684

Authorization for Release of Medical Information

Patient Information:

Last Name:_____ First Name:_____ MI:_____

Previous Name(s):_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Information to be Released (Please check)	Date(s) of Service/Doctor		Information to be Released (Please check)	Date(s) of Service/Doctor
□ Doctor's Notes			□ Operative/Procedure Reports	
□ Lab and X-ray Reports			□ Physical Therapy Notes	
□ X-rays Films done at Premier Bone & Joint Centers			□ Other _____	

***THERE MAYBE A CHARGE FOR RECORDS. PLEASE ALLOW 10-14 BUSINESS DAYS.**

Reason for Release: (Please check)

□ Doctor □ Self □ Other _____

Recipient/Send Records To:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Special Instructions:_____

I HEREBY AUTHORIZE PREMIER BONE & JOINT CENTERS TO RELEASE INFORMATION ON THE ABOVE NAMED PATIENT TO THE RECIPIENT INDICATED. PREMIER BONE & JOINT CENTERS IS HEREBY RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM SUBSEQUENT RELEASE OF THE INFORMATION REQUESTED.

Patient Signature:_____ Date:_____

-- or --

Authorized Representative:_____ Date:_____

Relationship to Patient:_____

Witness: _____ Date: _____

□ ***Please check if records will be picked up at Premier Bone & Joint Centers***

This section must be completed for all Alcohol/ Drug /STDs /AIDS/HIV/Psychiatric Records. Alcohol/Drug/STDs/AIDS/HIV/Psychiatric Records are protected by Federal Regulation 42CFR, part 2. Release of such records requires specific consent. I hereby grant such specific consent.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____

For PBJC use only:

Records Released on _____

By (initials) _____

Payment Received _____

Revised 4/2013