Name: ______________________
DOB: ______________________
Age: ______________________
Date: ______________________

A Registered Trade Name of Gem City Bone & Joint, P.C.
1909 Vista Drive
Laramie, WY 82070
Telephone: (307) 745-8851 Fax: (307) 742-0961

PATIENT CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

TO: (Name and address of health care facility)

____
____
____

RELEASE TO: (Name and address to whom information is to be released)

Premier Bone and Joint Centers
1909 Vista Drive
Laramie, WY 82070

I request and authorize the above-named health care provider to release the information specified below to the organization/agency individual I have specified in this request.

_______ Copy of Complete Medical Record
_______ Copy of H&P, Discharge Summary, & Operative Reports
_______ Other: (specify) ______________________

Purpose of disclosure: ______________________

I authorize the release of information which may include information regarding the following:

_______ Drug abuse, if any
_______ Alcohol use, if any
_______ AIDS, if any
_______ Psychiatric conditions, if any

I make this consent upon the promise that all disclosures made pursuant to the authority granted by this consent shall be accompanied by a written notice which states:

> "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general Authorization for the release of medical or other information is not sufficient for this purpose."

This consent for release of confidential information expires in twelve (12) months, or as authorized by me. Expiration date cannot exceed twelve (12) months and will cover only information created twelve (12) months after authorization is signed. I understand I may revoke this Authorization at anytime, except to the extent that action has already been taken in compliance with this consent. This facility, its employees, and the attending physician are hereby released from legal responsibility or liability for the release of the above information.

____
Date

____
Print Name

____
Signature of Release

____
Signature of Patient

____
Expiration Date (Not to exceed 12 months)

____
OR Legally Responsible Person

____
Date of Birth

____
Specify Relationship