Rocky Mountain Family Medicine

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Rocky Mountain Family Medicine to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Rocky Mountain Family Medicine to use and/or disclose the individually identifiable health information about me per physician's needs to provide adequate care.

The information will be used or disclosed at the request of the individual.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on three year after last visit to Rocky Mountain Family Medicine.

I do not have to sign this authorization in order to receive treatment from Rocky Mountain Family Medicine. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Rocky Mountain Family Medicine
2241 Farnum St., Suite 102
Casper, WY 82609

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.