HIPAA Release Form for Ortho Montana

HIPAA Privacy Notice Highlights
This notice describes how health information about you (as a student athlete/patient being cared for by Ortho Montana and AMP) may be disclosed and how you can gain access to your health information. This is in compliance with HIPAA (Health Insurance Portability and Accountability Act 1996).

This declaration and release of medical information includes but is not limited to Rocky Mountain College; Montana State University Billings; Billings West High School; Billings Senior High School; Billings Central High School; Billings Skyview High School; Laurel High School; St Vincent's Healthcare; Riverstone Healthcare; Rocky Mountain College Health Services; Montana State University Billings Health Services; Yellowstone Surgery Center; Billings Clinic and the entities included in the health care service of the individual. Those associated with the above may provide and release information about your health care services to any entity requiring that information (team physicians; physicians and other hospital personnel; ATCs; coaches; physical therapists, occupational therapists and other rehabilitation staff; CMAs dentists; optometrists; chiropractors; insurance companies; billing and medical records departments for the above; school personnel to include Athletic Director and parents).

We may use and share information about you for treatment, insurance, business and administrative activities.

For other uses and disclosures, except as required by law, we will explain the use or disclosure and seek your permission.

Yours Rights and Choices
You may:

- Review, copy and ask us to amend certain health information (if believed to be incorrect) we have about you;
- Ask for a list of certain disclosures we have made of that information;
- Ask use to deliver health information about you to an alternative address;
- Ask us not to share your health information with certain family members or friends.
- Where you have given us permission to use or share your health information, you may change your mind at any time. To exercise these rights or choices, contact your physician or ATC in writing.

I hereby acknowledge that I have been presented and have read the above notice of HIPAA regulations. I also waive my right to privacy and will allow the disclosure of my health information to the appropriate individuals/institutions.

Patient/Athletes Signature:_____

Date: _____

Witness: _____