Bruce Watkins, M.D

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Tetonhandsurgerypatient.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Medical Records Release From:

Provider / Entity Name: _____

Address: _____

City, State, Zip: _____

□ Clinic Notes

□ Operative Reports

□ Radiology Reports

□ EMG Report

□ Medications List

Records authorized to be released to: Teton Hand Surgery
1542 Elk Creek Drive
Idaho Falls, Idaho 83404
Fax: 833.513.0980

□ Fax
□ Mail
□ Pick up

I authorize the above named health care provider / entity to release the information or records specified to Teton Hand Surgery upon request using the method indicated above. My authorization will expire one year from the date of signature provided on this form. I understand that I am able to revoke this authorization at any time by sending in a written request to Teton Hand Surgery and or the above provider / entity and that by revoking this authorization will not affect disclosures made and or actions taken before the revocation is received. I understand that I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Parent or Guardian (Please Print) :_____

* Federal privacy regulations will no longer apply to the information disclosed, and Teton Hand Surgery may disclose the information