TRI-STATE ORTHOPAEDIC SURGEONS, INC.

Patient Authorization for Disclosure of Protected Health Information (PHI)

* *Please print. This form must be signed and dated. Incomplete forms may cause a delay in processing your request. Mail, fax or Email completed forms to: Tri-State Orthopaedic Surgeons, Inc., 225 Crosslake Dr., Evansville, IN 47715 * Fax: (812) 476-6867 * Email: medicalrecords@tristate-ortho.com*

Patient name: _____ **S.S.#:** _____-____-_____ **Date of birth:** ____/____/_____

Address: _____ **City:** _____ **ST:** ____ **Zip:** _____

Phone: (_____) _____-_____ **Work phone:** (_____) _____-_____ **Email:** _____

Authorization: I authorize Tri-State Orthopaedic Surgeons, Inc. to disclose or provide protected health information about me to the individual/entity listed below.

Individual/Entity name: _____

Address: _____ **City:** _____ **ST:** ____ **Zip:** _____

Phone: (_____) _____-_____ **Fax*:** (_____) _____-_____ **Email*:** _____

Is the individual named above a personal representative involved in your care? ☐ Yes ☐ No

Preferred method of disclosure: ☐ Hold for pick-up* ☐ Mail ☐ Fax* ☐ Email*

* *Two (2) forms of I.D. will be verified upon pick-up.*

* *Radiology films, CD's and images on other external storage devices cannot be faxed or emailed.*

* *Some fax and email transmission methods are not secure. Therefore, it is possible for your protected health information to be compromised during transmission from our practice. Do not designate fax or email as your preferred method of disclosure if this is of concern to you.*

Description of information to be disclosed: I authorize Tri-State Orthopaedic Surgeons, Inc. to disclose the following protected health information about me to the individual/entity identified above:

☐ Medical records with dates of service from: ____/____/_____ to ____/____/_____

☐ Entire medical record; **or**, ☐ Only the medical records selected below:

- ☐ Office/clinical notes
- ☐ Laboratory/pathology reports
- ☐ Radiology reports *(i.e., X-rays, MRI, ultrasound)*
- ☐ Physical/occupational therapy records
- ☐ Operative reports *(i.e., IP/OP surgery and procedures)*
- ☐ Neurological reports *(i.e., EMG, NCS or other diagnostic procedures)*
- ☐ Radiology images *(i.e., films, CD or other external storage device)*
- ☐ Only disclose the following: _____

Purpose for disclosure: ☐ Patient request ☐ Other *(please specify)*: _____

- **I understand** this authorization will expire in one (1) calendar year from the date this authorization is signed unless I specify an earlier expiration date. If applicable, please specify an earlier expiration date here: ____/____/_____.
- **I understand** it is my right to terminate this authorization at any time by written request to the attention of the Compliance Coordinator at Tri-State Orthopaedic Surgeons, Inc. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- **I understand** refusal to sign this form places no condition on the delivery of healthcare or treatment.
- **I understand** Tri-State Orthopaedic Surgeons, Inc. is not responsible for how my protected health information is used by the individual/entity I have authorized to receive it. Furthermore, I understand protected health information I have authorized Tri-State Orthopaedic Surgeons, Inc. to disclose, may no longer be protected by the requirements of HIPAA Privacy and Security Rules.

_____ _____/_____/_____

Patient or Authorized Representative Signature **Date**

* *You have the right to receive a copy of signed authorizations upon request.*