

TRI-STATE ORTHOPAEDIC SURGEONS, INC.

Patient Authorization for the Disclosure of Protected Health Information (PHI)

** Please print when completing this form, sign and date. Incomplete forms may delay your request. Mail, fax or Email completed forms to:
Tri-State Orthopaedic Surgeons, Inc., 225 Crosslake Dr., Evansville, IN 47715 * Fax: (812) 488-2258 * Email: medicalrecords@tristate-ortho.com*

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

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

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

☐ I authorize Tri-State Orthopaedic Surgeons, Inc. to disclose or provide PHI about me to the individual/entity named below.

☐ I authorize the entity/individual named below to disclose or provide PHI about me to Tri-State Orthopaedic Surgeons, Inc.

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 CDs 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 PHI 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 PHI about me to the individual/entity identified above:

☐ **Medical records dated:** ____/____/____ to ____/____/____ **Physician(s):** _____

Select medical records to be released below:

- | | |
|--|---|
| ☐ Office/clinical notes | ☐ Operative reports (i.e., IP/OP surgery and procedures) |
| ☐ Laboratory/pathology reports | ☐ Neurological reports (i.e., EMG, NCS or other diagnostic procedures) |
| ☐ Radiology reports (i.e., X-rays, MRI, ultrasound) | ☐ Radiology images |
| ☐ Physical/occupational therapy records | ☐ Entire medical record |

The 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 disclosure has already been made based on prior authorization.
- **I understand** the 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 PHI is used by the individual/entity I have authorized to receive it. Furthermore, I understand the PHI 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.