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 images will be delivered to your email and accessed via a HIPAA secure link. Images on CD are available only upon request.*

* *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
☐ 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
☐ 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 Department 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.*