AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

This authorization gives **Tri-State Orthopaedics & Sports Medicine, Inc**. and/or **Tri-State Physical Therapy (TSPT)** permission to use and/or disclose protected health information (PHI), including medical records and billing statements, (please note that an authorization is ***not*** required for the purposes of treatment, payment or healthcare operations).

Right not to sign: You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Tri-State Orthopaedics & Sports Medicine, Inc. or TSPT, except in the case of care that is solely for the purpose of creating healthcare information for disclosure to a third party (for example--pre-employment physicals, completion of disability or other forms, etc.). In those instances, we require a signed authorization.

Right to revoke: You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to the following address: Tri-State Orthopaedics & Sports Medicine/TSPT, Attn: Privacy Officer, 5900 Corporate Drive, Suite 200, Pittsburgh, PA 15237

Re-disclosure: Health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, which we cannot control or monitor (the federal privacy rule or another privacy law no longer protects it).

Authorized Uses and Disclosures of Health Information

1. Patient name: _____ Date of Birth: _____ SS#_____

2. Provide a detailed description of the information to be disclosed, (indicate information such as date of service, injury/body part, right/left/bilateral, & type of services including office, surgery, x-ray, therapy, etc.): _____

3. List the reason(s) / purpose(s) of the disclosures, in detail (**why** the information is being released): _____

4. Recipient—Provide the name of the person or entity (including a medical practice) to whom we can disclose or send the information (i.e.--indicate **who** we are giving or sending the information to):

Name: _____

Address: _____

Phone: _____ Fax*:_____

* Patient is responsible for insuring that fax number if provided is secure/private to comply with HIPAA Privacy regulations. Tri-State Orthopaedics is not responsible for unintentional receipt/interception of medical information sent to the fax number provided above.

5. Expiration of authorization—Provide a date or event that this authorization will expire:

_____

I have read and understand this authorization. I authorize Tri-State Orthopaedics & Sports Medicine and/or TSPT to use, release and/or disclose my health information as described in this authorization.

X_____ **X**_____

Signature of Patient (or Representative) **Date**

If applicable: _____

Name of personal Representative Relationship to patient

To view Notice of Privacy Practices go to www.tristateortho.com ***Return completed form to: Tri-State Orthopaedics & Sports Medicine Inc., 5900 Corporate Drive, Suite 200, Pittsburgh, PA 15237 or via FAX to 412-367-9862. Questions: Call 412-369-4000, ext 365.***