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). To view Notice of Privacy Practices go to www.tristateortho.com

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 or Tri-State Physical Therapy, 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: 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).

1. Patient Name: _____ Date of Birth: _____

2. Provide a detailed description of the information to be disclosed / released (include: date(s) of service, injury/body part, right/left, & type of services including office visit(s), surgery, x-ray, therapy, etc. Unless specifically indicated, physical therapy notes will not be released).
Note: X-rays are emailed or printed at no cost. There is a charge if an x-ray CD is requested.

_____

3. List the reason(s) for the request for release of medical records, in detail (**why** the information is being released):

_____

4. Provide the name of the person(s) or entity (including a medical practice, facility or physician) to whom we can disclose or send the information (indicate **who** will be receiving the information). All information will be sent via email from our copy service, Healthmark, unless otherwise noted.

Name: _____ Email: _____

Address: _____

Phone: _____ Fax*:_____

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

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

_____

*If no expiration date is written, this authorization will automatically expire one year from the "Date" signed below.

(Please note: Office notes are NOT automatically sent after every office visit. Even if you have a valid authorization that has not yet expired, you still must notify the office staff to release future office notes.)

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

X_____ **X** _____ **X**_____

Signature of Patient (or Representative) **Daytime Phone #** **Date**

If applicable:

_____ _____

Name of Personal Representative (or Parent if under 18) Relationship to Patient

Return completed form to: Tri-State Orthopaedics & Sports Medicine Inc., 5900 Corporate Drive, Suite 200, Pittsburgh, PA 15237
FAX to 412-367-9862 or Scan/Email as an attachment to medicalrecords@tristateortho.com.

Questions: Call 412-369-4000, ext 365. It may take up to 7 days to process records. Incomplete forms will cause further delays.