Request for Completion of Forms

Complete and return this Request to Tri-State Orthopaedics with full payment (complete 1 Request per form)

☐ Forms will be completed within 5-7 business days (**$15 per form**), or

☐ If you need forms sooner, check here. Please allow 1-2 days (**$25 per form**). Date needed by: _____

Authorized Uses and Disclosures of Health Information for Completion of Forms

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

2. Description of the information to be provided (what form/type of information is needed—date range, body part/injury):

_____

3. List the reason or purpose of the forms (who requesting and why the form is being requested or sent):

_____

4. *Recipient—Provide the name of the person or company which we can release, share or send the information (indicate who and where information/form to be sent):

*Company: _____*Contact Name:_____

*Address: _____

*Phone: _____ *Fax: _____

***Upon completion of the form(s), please indicate if you would like form(s) to be [check one]:**

☐ **mailed** to above address, or

☐ **faxed** to above fax number, or

☐ **picked up** by patient

We accept Cash, Check and Credit Card payments. (Checks made payable to: "Tri-State Orthopaedics & Sports Medicine")

5. Expiration of authorization—Provide a date or event that this authorization will expire (if unsure, put 30 days from today's date or "until disability resolved"): _____

6. Short Term Disability—Indicate if we are permitted to provide verbal updates to your STD carrier. ☐ Yes ☐ No

7. Medical Records are not automatically sent with completed forms. If medical records related to this claim are required, the carrier/employer will have to send a separate request to our Medical Records department for the release of those specific records. Your signature is required on the authorization to release medical records. If the carrier does not have a signed authorization from you, we will require you to complete one before we can process the request. (Visit our website at www.tristateortho.com and click the "Patient Info" tab and "Medical Records Request" for the form.)

I have read and understand this authorization and I authorize Tri-State Orthopaedics & Sports Medicine to use and disclose my health information to complete forms that I have requested (as described in this authorization).

X_____ X_____

***Signature of Patient (or Representative)** ***Today's Date**

* Indicates information required for subsequent requests for completion of forms for same purpose and company when authorization is still valid. If authorization expired, please complete entire authorization form.

This authorization gives **Tri-State Orthopaedics & Sports Medicine, Inc**. permission to use and/or disclose protected health information (PHI), including medical records and billing statements, (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. However, Tri-State cannot complete or release any forms without a signed authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Tri-State Orthopaedics, except in the case of care/evaluation that would be required for completing the requested forms to be disclosed to a third party (for example, a pre-employment physical, disability forms, etc.). In those instances, we may require a signed authorization prior to care/evaluation/consultation with a provider.

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, please submit a written revocation to the following address: Tri-State Orthopaedics & Sports Medicine, 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 be responsible. *Rev 9/2012*