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 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: 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 / 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):

_____

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):

Name: _____

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 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 (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 10-14 days to process records. Incomplete forms will cause further delays.