AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME | BIRTH DATE | SSN#

ADDRESS | CITY/STATE | ZIP

HOME PHONE # | CELL | WORK

EMAIL ADDRESS

CONSENT

(PLEASE SIGN AND DATE ON NEXT PAGE)

I authorize representatives from Trinity Medical Group to disclose Health Information as directed below:

1. RECEIVING PARTY

Please allow the following person/ persons to access my health information:

NAME | ADDRESS | PHONE #

NAME | ADDRESS | PHONE #

2. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

- Complete Medical Record
- Billing Records
- Partial Medical records. Please specify dates.

INFORMATION TYPE & DATES

History & Physical ______

Office Notes/ Progress Notes ______

Consultations ______

Operative Reports ______

Discharge Summaries ______

Pathology Reports ______

Lab Results ______

EKG Report ______

X-Rays ______

Itemized Bill ______

Appointment Info ______

Note: A copy of this completed, signed and dated form must be provided to the patient and/or patient's representative and a copy must be placed in patient's medical record.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (CONTINUED)

3. PURPOSE OF DISCLOSURE

- At my request
- In an emergency
- When unable to reach me

4. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, I understand that this authorization will expire on __________ (insert expiration date or event). If I do not specify an expiration date or event, this authorization will expire 365 days from the date which I signed this authorization.

5. RIGHT TO REVOKE AUTHORIZATION

I understand that if my health information is disclosed to a party other than a health care provider, health plan, or health care clearinghouse subject to federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

6. RE-DISCLOSURE

I understand that ID my health information is disclosed to a party other than a health care provider, health plan or health care clearing house subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

7. RELEASE AND WAIVER

If the health information that I have requested Trinity Medical Group to disclose contains any priviledged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as Acquired Immunodeficiency Syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), Human Immunodeficiency Virus (HIV), Veneral Disease, Tuberculosis, or Hepatitis, I hereby waive any priviledge concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Trinity Medical Group, each of their agents, and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

____

PRINT PATIENT'S NAME (OR PATIENT'S REPRESENTATIVE) DATE SIGNED

____

PATIENT SIGNATURE (OR PATIENT'S REPRESENTATIVE) DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT

____

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