

Authorization to Release Information

[Please Print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the specified medical facility to release your protected health information to Tristate Arthritis and Rheumatology. You can revoke this authorization at any time by submitting a request in writing to Tristate Arthritis and Rheumatology. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Section A. Patient Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)	Date of Birth: (Month/Day/Year)
Address: (including zip code)	Telephone Number: (including area code)

Section B. Medical Facility to Release Information

I authorize _____ to release my protected health information as described below.
(Medical Facility)

Section C. Recipient: (medical facility that will receive your information)

Medical Facility: Tristate Arthritis and Rheumatology	Telephone Number: 859-331-3100
Address: 2616 Legends Way, Crestview Hills, KY 41017	Fax Number: 888-263-4022

Section D. Description of the Information to be Released: (what type of information will be released)

Check **ONLY ONE** box:

- Psychotherapy notes** – Federal law requires a separate authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.
- All information related to the provision of and payment for my health care benefits or services.***
- Specific information as described on the line below:***

_____ Examples: Specific test results, office notes from specific dates

***NOTE:** State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information _____ (Initials)	HIV/AIDS _____ (Initials)
Substance/Alcohol Abuse _____ (Initials)	Mental/Behavioral Health _____ (Initials)

Purpose of Release: _____
Example: For medical care

Section E. Expiration: (when this authorization will end)

This authorization will expire (Check **ONLY ONE** box):

- When I revoke this authorization***
- Upon the following date, event or condition*:** _____

Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage.

* The party identified in Section B must be notified in writing of the event/condition to cancel or revoke this authorization.

Section F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the release of my protected health information as described above.

Personal Representative Information: A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

_____ (Print Name)	_____ (Printed Name of Patient Representative)	_____ (Description of Representative's Authority)
_____ (Signature of Patient)	_____ (Date)	_____ (Signature of Personal Representative)
_____ (Date)		_____ (Telephone Number)