

Please fax completed form to Tri Rivers at (412) 630-8019.

Last Name	First Name	M.I.	TRS# (office use)
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Request to Release Medical Records to a Third Party

Tri Rivers Surgical Associates, Inc. (The "Practice")

Section A: Patient's Authorization to Release Health Information

To authorize release of your health information, all items in this section must be completed fully.

I authorize _____ to release information from the medical records of:
(Tri Rivers Surgical Associates or Other Physician)

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

as described below, to:

Insurance Co., Employer or Physician **Name & Address:** _____

Insurance Co., Employer or Physician: **Phone:** _____ **Fax:** _____

Please provide a specific description of the type of information to be released, **including dates**. Be as specific as possible regarding what information you are requesting and how it will be used (form completion, continued medical care, etc.).

Section B: Notification of Your Rights as a Patient (or Patient's Representative)

You have the right to revoke this authorization prior to the below stated expiration date or event, except to the extent the Practice has already taken action in reliance on this authorization. The revocation will not be effective until it has been received by the Privacy Office. To revoke this authorization, a written revocation must be submitted to our Privacy Officer at: Tri Rivers Surgical Associates; 9104 Babcock Blvd., Suite 2120; Pittsburgh, PA 15237.

You may refuse to sign this authorization and this refusal will not affect your ability to obtain treatment. However, your information will not be released to the requested party. You have the right to inspect or copy any information used or disclosed under this agreement. You understand that if the person or organization that received the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations. You have the right to know specifically what information you are authorizing for release, who is going to use it and how it will be used. You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information.

Sign below to indicate that you agree to release the Practice, its health care providers, officers and other personnel from any legal responsibility or liability for disclosure of the above described information to the extent indicated and authorized herein, have read this authorization and agree with its terms.

This authorization will expire one year after date signed or on: Expiration Date: ____/____/____ (MM/DD/YYYY)

(Signature of patient or patient's representative) (Date)

(Printed name of patient or patient's representative) _____

If signed by the patient's representative the relationship to the patient and description of representative's authority to act for the individual MUST be provided here _____