TRINITY
HAND SPECIALISTS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO

TRINITY HAND SPECIALISTS

I authorize a copy of the medical information for _____ DOB _____
Full Name

FROM:		**TO:**
Name:	_____	Trinity Hand Specialists
Address:	_____	Fax 423-722-1682, Ph 423-282-5332
City, State, Zip:	_____	2335 Knob Creek Rd Suite 100
Phone #:	_____	Johnson City, TN 37604

The information will be used on my behalf for the following purpose(s): _____

By checking the spaces below, I specifically authorize the release of the following medical records, if such records exist:

(_____) Medical records needed for continuity of care (specify body part)_____

(_____) X-ray, EMG, MRI, CT, Bone Scan, Ultrasound reports

(_____) Therapy reports (PT or OT)

(_____) Other (please specify) _____

(_____) Please send the entire medical record (all information).

Separate signed authorization form required for the following:

HIV/AIDS related records	Genetic testing information
Mental health information	Drug/alcohol diagnosis, treatment or referral information

This authorization is limited to the following statement:

_____

This authorization is limited to the following time period:

_____

This authorization is limited to workers compensation claims for injuries of:

_____

- I understand that the information disclosed as directed by this authorization is subject to re-disclosure by the recipient and is no longer protected under federal law.
- I understand I do not have to sign this authorization and that my refusal to sign will not affect by ability to obtain treatment.
- I understand my information may be mailed or faxed depending on the urgency of the request.
- I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, the authorization will expire 1 year from the date of signing, or by another date if you specify above, whichever comes first.

_____ _____
Signature of patient or person authorized by law and relationship to patient Date

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HAND SPECIALISTS

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FROM

TRINITY HAND SPECIALISTS

I authorize a copy of the medical information for _____ DOB _____
Full Name

TO:

Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

E-mail (if known): _____

FROM:

Trinity Hand Specialists

Fax 423-722-1682, Ph 423-282-5332

2335 Knob Creek Rd Suite 100

Johnson City, TN 37604

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This authorization is limited to the following statement:

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_____

This authorization is limited to workers compensation claims for injuries of:

_____

- I understand that the information disclosed as directed by this authorization is subject to re-disclosure by the recipient and is no longer protected under federal law.
- I understand I do not have to sign this authorization and that my refusal to sign will not affect by ability to obtain treatment from Trinity Hand Specialists, nor will it affect my eligibility for benefits.
- I understand my information may be mailed, faxed, or emailed via HIPAA-compliant encryption..
- I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, the authorization will expire 1 year from the date of signing, or by another date if you specify above, whichever comes first.
- Trinity Hand Specialists, its employees, officers and physician are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Person making the request_____ Relationship to Patient_____

Signed _____ _____
Signature of patient or person authorized by law and relationship to patient Date