TRI-CITY ORTHOPAEDICS

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Kennewick, WA 99336
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HIPAA Release of Information Consent Form

Patient's Full Name | **Patient's Medical Record Number**

Address | **Patient's Date of Birth**

City, State, Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below. If Medical Records is selected, I authorize release of medical records upon **written** request to the individual(s) specified. If Billing is selected, I authorize release of billing information **verbally or written** to the individual(s) specified.

Name: _____ Relationship to Patient: _____ Medical Records: ☐ Billing: ☐

Name: _____ Relationship to Patient: _____ Medical Records: ☐ Billing: ☐

Name: _____ Relationship to Patient: _____ Medical Records: ☐ Billing: ☐

RELEASE OF INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH *WILL* OR *WILL NOT* BE DISCLOSED AS INDICATED BELOW:

YES, Disclose this information (initial here): _____

NO, **DO NOT** Disclose this information (initial here): _____

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying TCO in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- This authorization expires 1 year from date of signing.

Signature of Individual | **Date of Individual's Signature** | **Date of Birth**

OR, if applicable –

Signature of Guardian or Personal Representative of Patient's Estate*
**Must provide legal documentation (Power of Attorney, Legal Guardian, etc)*

Date of Guardian's/Personal Representative's Signature

Description of Authority to Actfor the Individual