Tri-State Progressive Health

Medical Records Release Form

1. Authorization

I authorize _____ to use and disclose the protected health information described below to Tri-State Progressive Health.

2. Effective Period
This authorization for release of information covers the period of healthcare from:

a. all past, present, and future periods_____

or

b. stated date range:_____ _____

3. Extent of Authorization

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). _____

4. This medical information may be used by the person/organization I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. _____

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. _____

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. _____

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. _____

Signature of patient or personal representative:

Printed name of patient or personal representative and his or her relationship to patient:

Date:
