TRI-STAR SYSTEMS

HIPAA Release Form
Authorization to Disclose Health Information

Participant Name: _____

Employer: _____

Social Security or Tri-Star Account #: _____

Authorization

I, _____, hereby authorize Tri-Star Systems to disclose specific health information from the records of the above named participant to: (Recipient Name/Relationship/Phone)

_____

Specific information to be disclosed:

☐ All Tri-Star Account Information, or

☐ Account Information Limited to: _____

I understand that:

- The information used or disclosed may be subject to re-disclosure by the person or call of persons or facility receiving it, and would no longer be protected by federal policy regulations.
- This authorization is voluntary and I may refuse to sign it.
- This authorization is valid until revoked and I must revoke this authorization by notifying Tri-Star Systems in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- No financial or in-kind compensation or remuneration is received in exchange for using or disclosing this information.
- Any re-disclosure of information disclosed to the participant by the participant is no longer protected by federal privacy laws.

_____ _____

Signature of Participant Date

_____ _____

Signature of Representative & Relationship to Participant Date

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Revocation Section

Please revoke the authorization for _____ to have access to my account information effective _____ (date).

_____ _____

Signature of Participant Date

Submit Form:

Fax: 800.818.0829 or

Mail: 16401 Swingley Ridge Rd, Ste. 250, Chesterfield, MO 63017