TRI-STAR SYSTEMS

HIPAA Release Form
Authorization to Disclose Health Information

Participant 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 (select one):

☐ All Tri-Star Account Information

☐ 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

This authorization was revoked on _____

Date

_____

Signature of Participant or Representative

Fax completed form to: (314) 985-0277