Instructions to Patients for Completing

TridentCare

HIPAA Privacy Authorization Form

Dear Patient:

If you would like some person(s), category of persons or organization, to have access to your personal health information, and you would like to allow TridentCare to release such information to that person(s), category of persons or organization, you must authorize TridentCare to release your personal information in writing.

You will need to complete this form even if you have a Durable Power of Attorney for Health Care in place. Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information to the person named while you remain competent. If you want some person, other than yourself, to have access to that information now, while you remain competent, you need to complete and sign that attached MobilexUSA HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

To complete this form, please follow these instructions:

Section A: Patient Information:
Indicate the **name, date of birth, address and phone number** of the patient (or individual) whose health information is being requested for release. Please insert this information in each box, as indicated.

Section B: Authorized Person(s):
Indicate the **person(s), category of persons, or organization** that is being permitted to receive the requested information from TridentCare. Please be sure to include the name of the person(s), category of persons, or organization and their **complete mailing address and telephone number** in each box, as indicated.

Section C: Information to be Released:
Describe the **specific health information** of the patient that should be released, the **dates of treatment or service** that are related to the information and the **reason for releasing** this information. Please insert this information in the spaces indicated.

Section D: Authorization Expiration:
Indicate how long the authorization is to remain effective by providing the **date or event** upon which the authorization will end. Please insert this information in the spaces indicated.

Section E: Patient's Rights:
This section contains statements that describe the patient's rights and understanding of those rights regarding this authorization. For example, the patient has the right to revoke this authorization at any time. **Please read this section.**

Section F: Patient or Representative's Signature:
The patient or the patient's representative must **sign and date** the completed authorization form. If the authorization is signed by the patient's representative, the representative should also include his or her relationship to the patient and provide their printed name. The signed authorization should be returned using the following methods:

Mail to Mrs. Jessica McDwyer, Medical Records and Privacy Specialist, TridentCare, 930 Ridgebrook Road, Sparks, MD 21152, fax to Mrs. McDwyer at (484) 398-7210, or email to medicalrecords@tridentcare.com.

Please make a photocopy this form and maintain a copy for your records.

TridentCare

HIPAA Privacy Authorization Form

Authorization for Disclosure of Protected Health Information

Section A – Patient Information (individual whose information will be released):	
Patient Name: (Last, First, Middle Initial, Title)	**Date of Birth:** MM/DD/YYYY
Address: (street, city, state, zip code)	**Phone Number:** (add area code)

Section B – Authorized Person (person(s) or organization to receive patient's information)

I authorize TridentCare, with headquarters at 930 Ridgebrook Road, Sparks, MD 21152 to disclose the above patient's protected health information to:

_____

_____

(Please include the name, address, and phone number of the person(s), category of persons or organization to whom the patient's information will be sent)

Section C – Information to be Released: (type of information to be sent).

1. **Description of the Information to be Disclosed**: (Type of information that will be released. Please check only the types of information that apply to this request)

   ___ X-ray Films ___ Ultrasound Films ___ Lab Results ___ Radiologist Report

   ___ Medical Record ___ Billing Information ___ Payment Information

   ___ Other (please specify): _____

   _____

2. **Date(s) of Treatment and/or Service related to the Information to be Disclosed**: (Specify the date or range of dates that TridentCare provided treatment or service(s) to the patient related to the requested information).

   From: _____/_____/_____ To: _____/_____/_____
   MM DD YYYY MM DD YYYY

3. **Reason for the requested Disclosure of the patient's information**: (Please specify)

   _____

   _____

(Examples: At my request; To my family member who assists with my health care decisions; To my employer, etc.)

SECTION D – Authorization Expiration: (date or event on which this authorization will end)

This authorization to release the patient's health information will expire on:

Date: _____/_____/_____ or Event: (please specify): _____
MM DD YYYY

SECTION E – Patient's Rights: (patient's rights under this authorization)

I understand that:

1. If the person(s), category of persons or organization receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
2. I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment for my health care.
3. I may revoke this authorization in writing at any time by sending written notification to the Privacy Office at 930 Ridgebrook Road, Sparks, MD 21152. My notification will not apply to actions taken by TridentCare prior to the date TridentCare receives my written request to revoke this authorization.

SECTION F –Patient or Representative's Signature: (please sign and date this authorization)	
Signature of Patient or Representative:	**Date:** (MM/DD/YYYY)
Representative's Relationship to Patient: (if applicable)	**Representative's Printed Name:**
Notary	