

TRI STAR MEDICAL PARTNERS, INC.

**PATIENT AUTHORIZATION TO RELEASE OR DISCUSS
PATIENT PROTECTED HEALTH INFORMATION (PHI)
WITH OTHER INDIVIDUALS**

By Federal law, Tri Star Medical Partner's Inc. must obtain your authorization to release or discuss your Protected Health Information (medical condition or test results) with other individuals. For example: your spouse, children, parents, family, friends or caregivers.

I, _____ the patient, authorize Tri Star Medical Partner's Inc. to release and or discuss my medical Protected Health Information (PHI) with the following persons or organizations.

Name (print)

Relationship (print)

- By law, this authorization is good for 90 days (3 months) from the time I sign this authorization.
- This authorization is revocable at any time in writing by the Patient or Tri Star Medical Partner's Inc.
- If after 90 days (3 months), the Patient or Tri Star Medical Partner's Inc., has not revoked this authorization, it will continue to rollover as your authorization for each of the next three (3) - 90 day periods (9 months).
- After a total of one (1) year, this authorization will terminate and you will be require to complete a new authorization.

I have read, understand, and have identified individuals or organizations I authorize Tri Star Medical Partner's Inc. to release or discuss my Protected Health Information (PHI).

Patient Signature of Authorization

Date of Authorization