TRYON MEDICAL PARTNERS

CONSENT TO DISCLOSE HEALTH INFORMATION

(HIPAA AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF HEALTH INFORMATION)

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I, _____, permit Tryon Medical Partners to disclose and release my protected health information as described below.

I. My Authorization

I authorize the disclosure of the following health information (check either A or B).

☐ - **(A)** All of my health information, OR

☐ - **(B)** All of my health information, EXCEPT (check as appropriate), OR

- ☐ - Mental health records
- ☐ - Communicable diseases (including HIV and AIDS)
- ☐ - Alcohol / drug abuse treatment
- ☐ - Other (please specify): _____

☐ - **(C)** I do NOT authorize disclosure of my health information to anyone. (Proceed to page 2.)

Tryon Medical Partners may disclose this health information to the following recipient(s):

Name (and Title) or Organization	Relationship to Patient	Date of Birth or Tax ID #	Phone Number	Purpose
				☐ - Request of Patient ☐ - Cont'd patient care ☐ - Insurance ☐ - Legal ☐ - Other:
				☐ - Request of Patient ☐ - Cont'd patient care ☐ - Insurance ☐ - Legal ☐ - Other:
				☐ - Request of Patient ☐ - Cont'd patient care ☐ - Insurance ☐ - Legal ☐ - Other:

Termination Date: This authorization becomes effective on the date I sign it and will stay in effect until I request that it be revoked OR on this TERMINATION DATE: _____.

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II. My Rights

- I understand that I am authorizing the individuals and/or entities listed above to have access to my protected health information. This document allows my medical information to be shared face-to-face, over the phone, or in writing. Tryon Medical Partners, PLLC staff will use reasonable efforts to confirm the identity of authorized parties before this information can be shared.

- I have the right to revise or revoke this document at any time by signing an updated form at any Tryon Medical Partners, PLLC location or by sending a signed, written request to:

Tryon Medical Partners, PLLC
Attn: Privacy Official
5950 Fairview Rd. Suite 330
Charlotte, NC 28210

- I understand that uses and disclosures already made based upon my original permission cannot be taken back.

- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____

Signature of Patient, Legal Guardian, or Personal Representative Date

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age
☐ - Patient is unable to sign because: _____

_____

Signature of Authorized Representative Date

_____

Print Name of Authorized Representative Date

Authority of representative to sign on behalf of the patient: ☐ Parent ☐ Legal Guardian
☐ Court Order ☐ Other: _____

For office use only:
Employee Name: _____ Date: _____