DEPARTMENT OF HUMAN RESOURCES
505 South McColl Road Suite A • Edinburg, Texas 78539 • (956) 318-2660

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE
This form complies with the HIPAA Privacy Rule

Patient Name: _____ DOB: _____
Street Address: _____ SS#: XXX-XX-_____
City: _____ State: _____ Zip Code: _____

TRISTAR RISK MANAGEMENT
P.O. BOX 2805
CLINTON, IA 52733
And its agents have access to ALL Medical Records

Specify dates (or date ranges), if applicable: _____

This request is for the purpose of obtaining any and all medical records.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and tendered to the privacy officer of the above named facility authorized to make this decision. I understand that the revocation does not apply information that has ahead been released in accordance to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and, or copy the information to be disclosed. I understand the authorizing this disclosure of my health information. I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV), sexually transmitted disease, tuberculosis or genetics.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE: _____

_____ _____
Signature of patient or authorized representative Date

_____
Description of Representative's Authority

_____ _____
Witness signature required Signature of witness

This HIPAA release expires on: _____