



**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  
(Participant or Personal Representative)

disclose specific health information from the records of the above named participant to :

\_\_\_\_\_  
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): \_\_\_\_\_

\_\_\_\_\_

Specific information to be disclosed: \_\_\_\_\_

\_\_\_\_\_

I understand that this authorization will expire on the following date, event, or condition:

\_\_\_\_\_

I understand that if I fail to specify an expiration date, event or condition, this authorization is valid until revoked, by completing and signing the *Revocation Section* of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information. I further understand that I may request a copy of the signed authorization.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

\*\*\*\*\*

NOTE: This authorization was revoked on \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Privacy Officer

**Revocation Section**

I do hereby request that this authorization to disclose health information of \_\_\_\_\_ signed by \_\_\_\_\_  
*(Name of Participant)* *(Name of Person Who Signed Authorization)*

on \_\_\_\_\_ be rescinded, effective \_\_\_\_\_. I understand that  
*(Date of Signature)* *(Date)*

any action taken on this authorization prior to the rescinded date is legal and binding.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date