Authorization for Use and Disclosure of Protected Health Information

TRINITY

SECTION A: Individual authorizing use and/disclosure

Name _____

Address_____

City _____ State _____ Zip Code _____

Home Telephone Number _____ Mobile/Cell Number _____

Date of Birth _____ Social Security Number_____

Section B: The use and or disclosure being authorized

I authorize Trinity Medical Management L.L.C. and/or their employees and designated representatives, to receive and disclose my personal health information. This includes examining all of my medical records as may relate to any incident (past/present); medical history; any and all statements given by me; to obtain copies of such records as may be requested; to discuss my medical history, examination, and treatment with physicians, nurses, medics or other healthcare providers who have treated or examined me and with my employer I understand this PHI may include alcohol, drug use, psychiatric, HIV, AIDS testing and results, sexually transmitted diseases, Hepatitis B & C testing, Sickle Cell Anemia and other sensitive information. I agree to release any of the above. Initial _____. If not applicalbe, check here. □

Purpose of this authorization:

- ☒ Workers Compensation (excluded from HIPAA)
- ☒ Treatment Payment Operations
- ☒ Employment Operations

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA privacy rule.

Section C: Expiration and revocation

Expiration: This authorization will expire three years from the date signed.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the person (s) designated below. I understand that revocation of the authorization will not affect any action taken in reliance on this authorization before my written notice of recocation was received.

Contact: **Bruce L. Wilkerson, MD**
Trinity Medical Management, LLC
Post Office Box 83357
Baton Rouge, LA 70884-3357
Phone: 225 769-4983
Fax: 225 769-4984

I _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information as described in this form and as described in the Notice of Privacy Practices. A copy of the Notice Of Privacy Practices has been made available to me.

Signature: _____ Date: _____

PATIENT IS ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER IT IS SIGNED