



RELEASE OF MEDICAL INFORMATION FORM

Participant Information

Participant Name:
Employer: BRAND
Social Security or Tri-Star Account #:

Authorization

I, (Participant or Personal Representative), hereby authorize Tri-Star Systems to

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

(Name(s) & relationship of authorized person(s).)

for the specific purpose(s): Authority to discuss all medical accounts and related expenses administered by Tri-Star Systems.

Specific information to be disclosed: All account information on file with Tri-Star.

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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NOTE: This authorization was revoked on Date Signature of Privacy Officer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on _____ be rescinded, effective _____.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any action taken on this authorization prior to the rescinded date is legal and binding.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