Tririga Rehab, LLC

800 W LONG LAKE RD, SUITE 103
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AUTHORIZATION TO USE AND DISCLOSE SPECIFIC HEATH INFORMATION (Pursuant to HIPAA)

By signing this Authorization, I hereby direct the use or disclosure by

_____

of certain medical information pertaining to my health, my healthcare or me.

This Authorization concerns the following medical information about me:

_____

This information may be disclosed by you and used by:

Tririga Rehab LLC, LLC, 800 W. Long Lake Rd, Suite 103, Bloomfield Hills, MI 48302; (248) 480-0900, its billing agents and affiliated parties, including but not limited to their legal representatives.

I understand that I have the right to revoke this Authorization at any time, except to the extent that the medical provider has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to this medical provider.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for this medical provider to use my protected health information for treatment, payment and health care operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested for the following purpose(s):

( ) at my request
( ) other purpose. Please state: _____

I understand that the medical provider will not condition its treatment on whether I sign this authorization. I acknowledge that I have the read the provisions in the Authorization, have received a copy of this authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

_____ _____
Signature Date

_____ _____ _____
Printed Name Social Security Number Date of Birth

If patient is a minor, describe the legal relationship of the minor with the person signing the authorization. If personal representative or legal guardian, attach a copy of the Letters of Authority.

This Authorization expires on: _____ (Date or Event)

Subscribed and sworn to before me on this _____ day of _____, 20___.

_____
Notary Public