



Tri Rivers
SURGICAL ASSOCIATES, INC.
*Orthopedic Surgery and
Musculoskeletal Medicine*

Consent to Release Medical Information

Tri Rivers Surgical Associates

TRS# (office use): _____

Personal Information

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: _____ Social Security #: _____

Parent/Guardian if patient under 18 yrs of age: _____

Consent and Primary Care Physician (PCP) Information

I hereby authorize the physicians and staff of Tri Rivers Surgical Associates (TRSA) to release information related to my medical care to the doctor listed below. I understand that information may also be released to my health insurance carrier or other insurance carrier when required. Information may be released to these parties via mailed/faxed office notes or by verbal communication.

PCP Name: _____ PCP Phone #: _____

PCP Address: _____

I will notify TRSA in writing if I wish to discontinue communication with the above-listed physician. I will also notify TRSA in writing of any changes regarding my PCP if I wish to have communications sent to a different physician.

Signature

Patient/Guardian Signature: _____ Date: _____
(Consent not valid unless signed and dated)

If you do not wish to authorize the release of your records, please write "DO NOT RELEASE MY RECORDS" across the release form, and sign and date the form. This authorization is not intended to limit, in any way, the general consent signed by the patient for treatment, payment or health-care operations.