A Patient’s Guide:

Authorizing Another Person to Access Your Medical Records

September, 2013
Purpose of This Guide
As a TriCore patient, you may want an individual other than yourself to access your TriCore records. For example, you may want to ensure that your spouse or child can access your records in addition to yourself. The Privacy Rule of the federal Health Information Portability and Accountability Act of 1996 (HIPAA), as a means to ensure the privacy and confidentiality of patient records, requires that you specifically authorize other persons to access your records. This is required even in the case of spouses and other close relatives. If you are a competent adult over the age of 18, your authorization is required in any and all cases where you want another individual to access your “Protected Health Information” as your records are called by HIPAA. (Parents generally have the exclusive right of access to the medical records of a child under 18.)

To enable you to authorize someone else to access your records, TriCore provides the form, “Patient Authorization to Disclose Protected Health Information.” This Guide provides you with a copy of the form (the last page of the Guide), and step-by-step instructions for completing and submitting it to TriCore.

If at any time you would like further assistance in completing the form, please contact TriCore Medical Records at 505-938-8803 or 800-245-3296 ext. 8803, or by email to legal@tricore.org
Step-by-Step Instructions for Completing the “Patient Authorization to Disclose Protected Health Information.”

Please refer to the sample completed form on page 4.

A. Who Are You?

<table>
<thead>
<tr>
<th>Top Line: Print your Last Name and your First Name in the blanks provided.</th>
</tr>
</thead>
</table>
| Second Line: Fill in your Date of Birth (DOB) with 2 digits for the month, 2 digits for the day, and 4 digits for the year. For example, 06/14/1951 for June 14, 1951. Fill in the last 4 digits of your Social Security Number (SSN). 

_Name, DOB and SSN ensure that we identify the records that belong to you._

Fill in your Daytime Phone Number so that we may contact you if we have questions about your completed form. |

B. What Records Do You Want the Authorized Person to Access?

1.a. Your records are organized by “Dates of Service,” the dates when TriCore performed tests on your blood, urine, tissue, etc. Fill in the range of Dates of Service you want the authorized individual to access. As in Date of Birth, use 2 digits for the month and day and 4 digits for the year. For example, fill in 03/01/2011 through 07/30/2013 for the Dates of Service March 1, 2011, through July 30, 2013. You may want to make the ending Date of Service the same as the Expiration Date you fill in on the bottom of the form. That way your form covers the longest possible time.

1.b. You next need to specify what kind of records you are authorizing the individual to access. You may specify the kind as ONLY that of specific tests (for example, Protime) OR you may check one of the boxes: Laboratory Medical Records, Laboratory Billing Records, or Laboratory Medical And Billing Records.

1.c. New Mexico has special protections for 6 kinds of health records. In this section you initial any/all of the 6 types of records that you want the authorized person to access. For example, if your name is Henry Smith, you fill in your initials “HS” in any/all of the blanks.

C. Who Are You Authorizing to Access Your Records?

2. Print the Last Name and First Name of the person on the first line, and their street or mailing Address on the second line.
D. Finishing Up

<table>
<thead>
<tr>
<th>Action</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign</td>
<td>Sign the form on the Signature of Patient line.</td>
</tr>
<tr>
<td>Date</td>
<td>Using 2 digits for month and day and 4 digits for year, fill in the date you sign the form on the Date of Signature line.</td>
</tr>
<tr>
<td>Expiration Date</td>
<td>Using 2 digits for month and day and 4 digits for year, fill in an expiration date.</td>
</tr>
<tr>
<td>Date</td>
<td>We recommend that you fill in 5 years from the Date of Signature. For example, if the Date of Signature is 08/10/2013, fill in 08/10/2018 for the Expiration Date.</td>
</tr>
<tr>
<td>Read</td>
<td>Read over the entire form to ensure (1) you know what it says, and (2) the information you provided is correct.</td>
</tr>
</tbody>
</table>

What Do You Do With Your Completed Form?

You may

- Turn it in at any TriCore facility (for locations go to tricore.org),
- Mail it to:
  TriCore Reference Laboratories
  PO Box 25024
  Albuquerque, NM 87125,
- Fax it to: 505-938-8211, or
- Email it to: legal@tricore.org

Then,
Your form will be reviewed for approval by Medical Records. If we have any questions, we will phone you at the daytime phone number that you listed.

It’s Done
Your approved form will be kept on file. If/when the person you have authorized to access your records requests them from TriCore, after verifying that person’s identity, we will see from the form that you have authorized the person to access your records, and release your records to her/him.

If at any time you would like further assistance in completing the form, please contact TriCore Medical Records at 505-938-8803 or 800-245-3296 ext. 8803, or by email to legal@tricore.org
PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all items marked with ⊗

Please Print: ⋆Patient Last Name Simpson ⋆Patient First Name Gloria

⋆DOB: 04/21/1967 ⋆SSN: XXX-XX-2722 ⋆Daytime Phone Number (505) 777-8888

(DD/MM/YYYY)

AUTHORIZATION

I authorize the disclosure of my protected health information as described herein.

1. Pursuant to the HIPAA Privacy Rule, I authorize TriCore Reference Laboratories to disclose the protected health information described in 1.a., 1.b. and 1.c.

   ⋆1.a. The records authorized to be released include Dates of Service 01/01/2013 through 10/17/2018
   ⋆1.b. The records authorized to be released include ONLY ________________________________

   OR (check only one)

   [ ] Laboratory MEDICAL RECORDS [ ] Laboratory BILLING RECORDS [V] Laboratory MEDICAL AND BILLING records

⋆1.c. New Mexico Specially Protected Information – I acknowledge that such records may include and/or contain information regarding any or all of the following conditions or diseases and the treatment thereof. I specifically authorize disclosure by INITIALING ALL THAT APPLY (types not initialed will NOT be disclosed):

Any and all information and laboratory records that relate, in any way, to any

   [ ] GS drug/alcohol/substance abuse testing, history or treatment
   [ ] GS emotional/behavioral health/psychiatric testing, condition or treatment
   [ ] GS Human Immune Deficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS) testing or treatment
   [ ] GS Sexually Transmitted Diseases testing or treatment
   [ ] GS genetic testing

⋆2. I authorize the following person(s) to receive the protected health information described in paragraphs 1.a., 1.b., 1.c.:

Please Print: Last Name Simpson First Name Robert

Please Print: Address 3221 Redwood St., Albuquerque, NM 87112

3. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

4. I understand that I may revoke this Authorization at any time by sending a letter to TriCore Reference Laboratories, except to the extent that TriCore Reference Laboratories may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by TriCore Reference Laboratories will not be affected in any way.

5. This authorization does not permit the person or organization listed in Paragraph 2 (two) to obtain or request from TriCore Reference Laboratories oral statements, opinions, interviews, or reports that are not already in existence.

6. If applicable, copying costs will be borne by the person or organization named in paragraph 2 (two).

7. This Authorization will expire one year from the date it is signed if no expiration date is listed below.

8. A photocopy or facsimile of this Authorization is as valid as an original.

9. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient and therefore be no longer protected by federal confidentiality rules.

⋆Signature of Patient Gloria Simpson

⋆Date of Signature 01/17/2013 ⋆Expiration Date (not to exceed 5 years) 10/17/2018

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all items marked with ⊗⊗

Please Print: ⊗⊗ Patient Last Name ___________________________________ ⊗⊗ Patient First Name ______________________________

⊗⊗ DOB: _______/_______/________ ⊗⊗ SSN: XXX-XX-_________ ⊗⊗ Daytime Phone Number (____) _______ - _______

(MM/DD/YYYY)

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I authorize the disclosure of my protected health information as described herein.

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⊗⊗ 1.b. The records authorized to be released include ONLY ____________________________________________________________

OR (check only one)

□ Laboratory MEDICAL RECORDS □ Laboratory BILLING RECORDS □ Laboratory MEDICAL AND BILLING records

⊗⊗ 1.c. New Mexico Specially Protected Information – I acknowledge that such records may include and/or contain information regarding any or all of the following conditions or diseases and the treatment thereof. I specifically authorize disclosure by INITIALING ALL THAT APPLY (types not initialed will NOT be disclosed):

Any and all information and laboratory records that relate, in any way, to any

_______ drug/alcohol/substance abuse testing, history or treatment

_______ emotional/behavioral health/psychiatric testing, condition or treatment

_______ Human Immune Deficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS) testing or treatment

_______ Sexually Transmitted Diseases testing or treatment

_______ genetic testing

⊗⊗ 2. I authorize the following person(s) to receive the protected health information described in paragraphs 1.a., 1.b., 1.c.:

Please Print: Last Name ____________________________________     First Name __________________________________________

Please Print: Address __________________________________________________________________________________________

3. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

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⊗⊗ Signature of Patient ________________________________________________

⊗⊗ Date of Signature _______/_______/________ ⊗⊗ Expiration Date (not to exceed 5 years) _______/_______/________


TriCore Reference Laboratories

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