



Access to & Release of Health Information

I understand that Triskele may document medical and other information related to my treatment in electronic and other forms. I agree that Triskele may use and disclose my sensitive health information for treatment, payment, and healthcare operations purposes in the same ways that HIPAA and other similar laws permit. I authorize my providers(s) and Triskele's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Triskele's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

We may update our Access to & Release of Health Information, at any time. The new document will be effective at that time. Upon your request, we will provide you with a revised Access to & Release of Health Information. You may request a revised version by calling the office and requesting that a revised copy be sent to you via email or asking for one at the time of your next appointment.