

TSCN HIPAA AUTHORIZATION

Permission to obtain and share health information for care coordination

PATIENT INFORMATION

Patient full legal name

Date of birth (MM / DD / YYYY)

Cell phone

Email

Mailing address

AUTHORIZATION SCOPE

Release all medical records related to care by my TSCN member doctors.

About TSCN

TSCN, LLC provides care-coordination and administrative services as a business associate of participating treating practices. Your doctors remain responsible for your medical care.

My permission

I authorize my referring doctor, that doctor's practice or clinic, and other doctors who are members of that same practice or clinic to release all medical records related to care by my TSCN member doctors to TSCN, LLC care coordinators acting for my treating practice. I authorize TSCN to receive, securely maintain, and make those records available to doctors and practices actively involved in my care, for treatment and care coordination, under TSCN's applicable agreements with my treating practices.

Purpose

To obtain relevant records, coordinate my care, arrange care, communicate between my treating providers, and help them understand my care and follow-up. This permission does not appoint TSCN as my medical decision-maker.

Information covered

All medical records related to care by my TSCN member doctors are covered, subject to the time period and any limitations I specify. This authorization does not cover separately maintained psychotherapy notes, substance-use-disorder records protected by 42 CFR Part 2, or other information requiring a separate permission under applicable law. Separate permission will be obtained when required. This authorization does not permit sale of my information or use for marketing, and does not authorize disclosure to attorneys, employers, insurers, or claims administrators.

Continue to page 2 for your choices, rights, and signature.

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When permission ends

Unless I specify an earlier date below, this authorization expires one year after the date I sign it.

My choices and rights

Signing is voluntary. My treatment, payment, health-plan enrollment, or eligibility for benefits will not be conditioned on signing this authorization. Without permission, some requested coordination may be limited; I can discuss other ways to transfer records with my doctor. I may revoke this authorization at any time by writing to TSCN Privacy Contact at support@tscn.care or 411 Route 17S, Suite 110, Hasbrouck Heights, NJ 07604, and by notifying the providers using this authorization. Revocation does not undo disclosures or other actions already taken in reliance on it. TSCN may verify my identity before acting on a request. Information disclosed under this authorization could be disclosed again by a recipient and may no longer have HIPAA protection, although other laws or contractual duties may still apply. I am entitled to a copy of this signed authorization. This does not waive any legal privacy right or prevent a disclosure otherwise permitted or required by law.

MY CHOICES

Records period (optional): From _____ to _____

Information I do not authorize / other limits (optional):

Earlier expiration date, if chosen: _____

Leave blank for expiration one year after the signature date.

SIGNATURE & ATTESTATION

I have read this authorization, had the opportunity to ask questions, and understand the permission I am giving. If I sign as a personal representative, I identify my authority below; TSCN or the treating practice may verify that authority.

Patient or representative signature

Date signed

Printed name of signer

REPRESENTATIVE ONLY - patient signers: skip this section.

Relationship to patient: _____ Legal authority: _____

If signing for the patient, attach documentation of your authority if available.

Print, sign, and scan both pages. Return to support@tscn.care.

Keep a copy of the signed authorization for your records.

Questions: support@tscn.care | (201) 819-0484

Privacy information: tscn.care/hipaa-notice-of-privacy-practices/