AK RHEUMATOLOGY

Authorization for Use and Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:

Phone Number:_____

RELEASE RECORDS FROM:

DOCTOR/ CLINIC:_____
ADDRESS:_____
_____
PHONE:_____
FAX:_____

TO BE SENT TO:

DOCTOR/ CLINIC:_____
ADDRESS:_____
_____
PHONE:_____
FAX:_____

Information to be disclosed (check all that apply):

❑ Entire medical record
❑ Most recent Clinic Note, Date: _____
❑ Clinical Notes, last 2 years
❑ Pathology Reports, last 2 years
❑ Laboratory Tests, last 2 years
❑ Other_____

Please do **not** send health information related to (check all that apply):

❑ HIV (AIDS virus) ❑ Drug/Alcohol Abuse ❑ Sexually Transmitted Disease (STD) ❑ Mental Health

Reason for disclosure:

❑ Transfer of Care ❑ Release to Another Physician ❑ Insurance Claim
❑ Second Opinion/Consult ❑ Legal/Attorney Review ❑ Personal Use
❑ Other_____

I authorize the use or disclosure of my health information as described above for the purpose listed. I understand that I have the right to withdraw permission for the release of my information at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed. Unless revoked in writing sooner, this authorization will expire 180 days from the date of signature below. I understand that this authorization is voluntary and I may refuse to sign this authorization without affecting my health care or the payment for my health care.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Name (if other than patient) Relationship to Patient

Revised: 05/2020