AK RHEUMATOLOGY

HIPAA RELEASE / NOTICE OF PRIVACY PRACTICES CONSENT FORM

By my signature below, I understand that I have been given the opportunity to review the Notice of Privacy Practices for AK Rheumatology and can also request a copy if desired.

Name of Patient or Patient Representative_____

Signature of Patient or patient Representative_____

Date_____ Relationship of Personal Representative Authority_____

PATIENT DISCLOSURE AND CONSENTS HIPAA RELEASE

I, _____(name of Patient) authorize AK Rheumatology to use and disclose a copy / discussion of health and medical information to the following :

I understand that this request will remain in effect until I request a change and fill out another form.

Name of Recipient_____Relationship to Patient_____

Name of Recipient_____Relationship to Patient_____

Name of Recipient_____Relationship to Patient_____

Signature of Patient_____ Date _____

1405 SE 164th Ave., Ste 201, Vancouver, WA 98683 | Phone 360-453-7068 | Fax 360-597-7581
admin@akrheumatology.com | www.akrheumatology.com