ARTHRITIS & RHEUMATOLOGY — CENTER PC —

Arthritis & Rheumatology Center PC
11685 Alpharetta Hwy, Suite 120
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Phone: 770-284-3150
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Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME_____
LAST **FIRST** **MI**

DATE OF BIRTH: _____/_____/_____ **SS#:**___-___-___ **MEDICAL RECORD #**_____

_____
ADDRESS **CITY** **STATE** **ZIP**

DAY PHONE:_____**EVENING PHONE:**_____

☐ I authorize the Arthritis & Rheumatology Center, P.C. to use or disclose my protected health information as indicated below to:

_____
Name of entity to receive this information

_____
ADDRESS CITY STATE ZIP
_____

☐ authorize_____
Name of entity to release this information

To release my protected health information to the Arthritis & Rheumatology Center, P.C. as indicated below.

INFORMATION TO BE RELEASED:	**PURPOSE OF DISCLOSURE:**
☐ From & To Dates_____	☐ Changing physicians
☐ History and physical exam	☐ Continuing care
☐ Office notes	☐ At patient request
☐ X-ray reports	☐ Second opinion
☐ Lab reports	☐ Legal
☐ Hospital records (op notes, discharge summary)	☐ Insurance/Workers' Compensation
☐ Medication records	☐ School
☐ Other: _____	☐ Other: _____

I understand that this authorization will expire: _____
Expiration Date or Defined Event

I understand that I may revoke this authorization at any time by notifying Arthritis & Rheumatology Center, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the Practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian Date