ARTHRITIS & RHEUMATOLOGY CENTER PC

Arthritis & Rheumatology Center, PC
Phone: 770-284-3150
Fax: 770-284-3170
Medical record fax: 404-905-5424

RELEASE OF MEDICAL RECORDS & PROTECTED HEALTH INFORMATION

PATIENT NAME_____ D.O.B_____
LAST FIRST

PHONE#: _____ SS#_____-_____-_____

_____
ADDRESS CITY STATE ZIP

Authorize_____
Name of entity to release this information

Phone: _____ Fax: _____

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**	○ **Insurance/Worker's compensation**
○ **Medication records**	○ **School**
○ **Other:_____**	○ **Other: _____**

I understand that this authorization will expire: _____
Expiration Date of 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 to the extent that the practice has acted in trust upon this authorization.

_____ _____
Signature of patient or legal guardian Date