

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: H) \_\_\_\_\_ Phone: W) \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**Please Note: Copy Fee May Be Charged For Medical Records**

Above listed patient authorizes the following healthcare facility to make record disclosure: **From:**

**Facility Name:** \_\_\_\_\_

**Facility Phone:** \_\_\_\_\_

**Facility Address:** \_\_\_\_\_

**Facility Fax:** \_\_\_\_\_

**City, ST, Zip:** \_\_\_\_\_

**The purpose of disclosure is:**

Ⓢ Change of Insurance or Physician

Ⓢ Continuation of Care

Ⓢ Referral

Ⓢ **Other** \_\_\_\_\_

**Please select which type of information to disclose:**

Current Records: Dates \_\_\_\_\_ Entire Medical Records \_\_\_\_\_

Specific Dates: \_\_\_\_\_

**Please: mail or fax. Ⓢ Will pick up records on** \_\_\_\_\_

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

**Release To:** *Athens Rheumatology Clinic, LLC*

**Address:** 1360 Caduceus Way, Building 200, Suite 102

**City, State, Zip:** Watkinsville, GA 30677

**Phone:** (706) 850-8322 **Fax:** (706) 850- 8366

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

X \_\_\_\_\_  
**Signature of Patient / Guardian or Authorized Representative**

**Date** \_\_\_\_\_

\_\_\_\_\_  
**Printed name of Authorized Representative Relationship / Capacity to patient**

**PLEASE ALLOW 7-10 BUSINESS DAYS FOR COMPLETION.**

MEDICAL RECORDS COPY FEE may apply \_\_\_\_\_ **THANK YOU!**