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 Fax: _____

Facility Address: _____

City, ST, Zip: _____

The purpose of disclosure is:

⑤ Change of Insurance or Physician

⑤ Continuation of Care

⑤ Referral

⑤ **Other**_____

Please select which type of information to disclose:

Current Records: Dates_____ Entire Medical Records _____

Specific Dates: _____

Please: mail or fax. ⑤ **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_____ **Date** _____

Signature of Patient / Guardian or Authorized Representative

_____

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!