



Authorization for Release of protected Health Information

Patient Name: _____

Address: _____

DOB: _____ Social Security Number: _____

I have been a patient at the Physician Practice or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I, _____ hereby authorize _____ to release my protected health information to _____.

The following information or copies of: (place a check by types of records desired)

- Allergy list
 - Hospital Documents (H & P, op notes, discharge summary, etc.)
 - Lab Results
 - Radiology Results (X-ray, CT, MRI, etc.)
 - Immunization Records
 - Medication list
 - Problem list
 - The above information and/ or the entire Medical Record which includes HIV-related information
 - The above information and/ or the entire Medical Record including mental health, drug or alcohol treatment
 - Entire Medical Record **EXCLUDING** HIV-related, mental health, drug or alcohol treatment
 - Billing or other business records (**specify**): _____
 - Other (specify): _____
- From (date): _____ to (date): _____

Reason for Request:

- Continuing treatment Insurance Legal Employer Study/ Research Second Opinion
- Other _____ I do not wish to enclose the reason

This authorization will expire in six months or _____

I understand that this authorization is subject to revocation at any time, except to the extent that Advanced Rheumatology and Arthritis Wellness Center, PC, or the above named individual, Facility, Agency, School or Entity has already taken action in reliance upon it. A photocopy or facsimile of this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive

Patient or Representative Signature

Date

Witness

Date