Authorization for release of health related information

Rheumatology Therapeutics
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I hereby authorize: _____ to release or make the authorized use and disclosed of the protected health information concerning my illness and or/treatment

Address: _____

Phone: _____ Fax: _____

Release information to:

_____

ADDRESS: _____

Phone: _____ Fax: _____

Please check that apply:

- ○ **X-ray circle one /Report**
- ○ **All Medical Records**
- ○ **DEXA reports**
- ○ **Lab results**
- ○ **MRI reports**
- ○ **Others** _____
- ○ **Date Of Service :** _____ **to** _____

I understand that I have the right to revoke this authorization but must be in writing and mailed to the above address. I am aware that my revocation is not affective to the extent that the persons I have authorized to use or disclose my protected health information have acted in reliance upon this authorization. I understand that a FEE may be charged for the transfer of my health information, or to obtain complete medical records, and I may be responsible for paying that fee.

Date: _____ Patient Date of birth: _____

Patient
Print name: _____ Phone #: _____

Patient
Signature: _____

Print & Signature of Legal Guardian or Caretaker on behalf of the patient:

_____

A copy of this authorization is as valid as the original. This release form will expires in 12 months.