RHEUMATOLOGY ASSOCIATES

12 Office Park Circle
Mountain Brook, Alabama 35223
Phone: 205-933-0320
Fax: 205-933-6400

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

Patient Name _____ Patient's DOB _____
Patient Address _____ Patient's Phone # _____
City, State, Zip_____

Persons/Facility providing medical records:
Rheumatology Associates, P.C.
12 Office Park Circle
Mountain Brook, AL 35223
Phone: (205) 933-0320 Fax: (205) 933-6400
Attn: Mary Jones

Persons/Facility receiving medical records:
Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

The type of information to be used or disclosed is as follows, please provide dates of service:
___Clinic Notes (_____ to _____) ___Lab Reports (_____ to _____)
___Radiology Reports (_____ to _____) ___Medication List (_____ to _____)
___Billing Records (_____ to _____) ___Other
If Other, please specify: _____

Purpose of Use or Disclosure:
___ Personal records
___ Sharing with other healthcare providers
___ Other (please describe) _____

1. I understand that the information in my health record may include information related to drug and/or alcohol abuse/treatment, behavioral or mental health services, or records pertaining to sexually transmitted diseases, if they are part of my record.
2. I understand that I have the right to revoke this authorization at any time. I understand that If I revoke this authorization, I must do so in writing, and that it will not apply to information that has already been released in response to this authorization. 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.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Date

_____
Signature of Witness

This authorization will expire 12 months from the date of signature