Integrative Rheumatology
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Authorization for Use/Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Contact Number: _____ Last 4 numbers of SSN: _____

I voluntarily consent to authorize INTEGRATIVE RHEUMATOLOGY, my physician and/or its administrative and clinical staff to share my health information with:

Facility Name & Provider: _____

Address: _____

Phone: _____ **Fax**: _____

☐ Send my records **FROM INTEGRATIVE RHEUMATOLOGY** to the facility/provider above

☐ Send my records from the facility/provider above **TO INTEGRATIVE RHEUMATOLOGY**

Information to be disclosed: I authorize the release of the following health information:
(check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

☐ Only the following records or types of health information: _____

- Dates of service requested: _____

I acknowledge that this authorization is voluntary. I also understand that if the person or organization I authorize to receive/release my protected health information is not a health plan or health care provider, my health information may no longer be protected by federal privacy regulations once it is disclosed. This authorization shall be effective until formally revoked in writing.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

[1] NOTE: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written proof may be requested)