FIBROmyALGIA OPT-OUT FORM

Date _____

PERSONAL INFORMATION

Full Name _____ Date of Birth _____

Address _____
Street *City* *Zip*

Preferred Phone ❑Cell Phone ❑Home Phone

Phone Number (____) ____-_____ Email Address _____

DECLINE TO PARTICIPATE

I decline to participate in the My Fibromyalgia program for management of my fibromyalgia. I understand that by declining to participate, I will not be able to continue treatment for fibromyalgia at Integrative Rheumatology. I understand that I am entitled to medications and urgent care by Integrative Rheumatology providers for at least thirty (30) days, after which I must transfer my medical care to another provider.

I understand that I can continue to receive full treatment for other rheumatologic conditions at Integrative Rheumatology.

_____
Patient Signature

RECORDS RELEASE

I authorize the release of the medical records regarding management of my fibromyalgia to the provider below. I agree to have labs, progress notes, and updated medication list sent to their office with the understanding that further management and therapeutic decisions are at the discretion of that provider.

Managing Provider: _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

_____
Patient Signature