RHEUMATOLOGY & DERMATOLOGY ASSOCIATES, PC

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Authorization to Release Medical Information

Physician to provide records:____

Patient Name:____

Date of Birth:__________________ Social Security Number:____________________

Person/facility to receive records:____

Address:____

City, State, Zip:____

Release the Records:	Initials:
1. Only records generated by this facility (not including records received from other sources)	_____________
2. All medical records at this facility	_____________
3. Only some portion of records maintained, specifically___________________________________	_____________

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORD RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the above provider to release the information specified to the organization, agency, or individual named on the request with the EXCEPTION of:

Initials:

______ Substance Abuse, if any ______ AIDS/HIV, if any ______ Psychological or Psychiatric conditions, if any

Other, please specify: ____

Expiration or revocation of authorization—I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date below. Use of copies—A copy of this authorization may be utilized with the same effectiveness as the original.

Patient Name (print):

____

Person authorized to sign for patient (print):

____

Patient or Guardian Signature:

____

Relationship:________________________________

Date:____________________________________