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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Today's Date:_____

1. PATIENT INFORMATION

_____
Name (Last, First) DOB

_____
Maiden/Other names

_____
Address City State/Zip:

Last 4 Digits of SSN: _____ Phone Number:_____

2. RELEASE INFORMATION FROM

_____
Name/Facility/Physician's Office Fax Number

_____
Address City State/Zip Code

FOR THE PURPOSE OF: ☐ Further Treatment/Continued Care ☐Other *(Specify)*_____

DATES OF SERVICE TO BE RELEASED: FROM_____ TO_____

I authorize the disclosure of all medical records and reports related to my medical history, physical condition, diagnoses, treatments, and prognosis. This includes x-rays, diagnostic reports, and any information pertaining to psychiatric or mental health issues, substance abuse, communicable diseases like AIDS or HIV testing, and any other relevant details about my treatment.

RECORDS TO BE RELEASED (*INDICATE ALL THAT APPLY***)**

☐Complete Health Records ☐History & Physical ☐Operative/Procedure Reports

☐Test Results/Reports*(E.g: Cardiac, Laboratory, Pathology, Radiology…)* Other: *(Specify)* _____

DO NOT DISCLOSE ANY INFORMATION IN MY RECORDS RELATED TO: _____

_____

3. RECIPIENT OF INFORMATION

_____
Name of Recipient Phone Number Fax Number

I acknowledge that I can withdraw this consent at any time by providing written notice to Ravenswood Rheumatology, except for any disclosures made in good faith before the revocation. I understand that information disclosed under this authorization may be further shared by the recipient and may no longer be protected by federal or state law. Ravenswood Rheumatology will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide this authorization. I am aware of my rights to: 1) Review or obtain copies of the protected health information that will be used or disclosed, as allowed by federal law (or state law if it provides greater access), 2) Refuse to sign this authorization, and 3) Receive a copy of this signed authorization. This authorization is valid for sixty (60) days from the date of the request and/or for the duration of the pending claim, unless otherwise specified.

4. **Signature/Designated Representative (***for minors or individuals with legal incapacity***)**

✗ _____ **Relation:**_____ **Date:**_____