arthritis CARE
RHEUMATOLOGY CARE | RESEARCH

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Authorization to Release Protected Health Information

(HIPAA Compliant Request for Information/Medical Records)

I hereby give permission to Arthritis Care and Research Center, Inc (ACRC) to release my, below checked, Protected Health Information (PHI) also known as My Medical Records to:

Be certain that information is accurate and complete. ***Incomplete authorizations are invalid.***

_____
Name of Medical Office/Company/Entity you want ACRC to send records.

_____
Street Address

_____
City State ZIP Code

_____
Phone Number Fax Number

☐ Release a copy of my entire chart including X-rays and lab reports

☐ Release records for this specific date of service_____

☐ Release specific information _____

I am requesting my PHI to be disclosed for reason_____

I understand the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I do not give permission for any other use or re-disclosure of this information.

I understand that this authorization will automatically expire one year from the date executed. I understand I may revoke this consent at any time in writing, except to the extent that action has already been taken.

I understand that I have a right to receive a copy of this authorization upon my request.

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____

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