STERLING GROUP RHEUMATOLOGY

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Board Certified Internal Medicine

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

PATIENT NAME:_____ DOB:_____

I authorize the use or disclosure of the above named individual's health information as described below. The following individuals or organizations are authorized to:

SEND RECORDS TO: *(physican & facility name)*

(address, phone, & fax number)

RECORDS COMING FROM: *(physican & facility name)*

(address, phone, & fax number)

The type of information to be used or disclosed is as follows:

History & Physical ◆ Lab Work ◆ Pathology Report ◆ X-Rays ◆ Diagnostic Studies ◆ EKG/Echo ◆ Progress Notes ◆ Emergency Room ◆ Physician Order ◆ Operative Reports ◆Discharge Summaries ◆ Other: _____

I understand the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

The information above may be used by or disclosed to or from Sterling Group Primary Care Clinic. The information for which I'm authorizing disclosure will be used for my personal records and sharing with other health care providers as needed.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing & present my written revocation to the CRMC Privacy Officers. I understand the revocation won't apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire on:_ _ _ _ _ _ _ _ _

I understand that once the above information is disclosed it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations. I understand authorizing the use or disclosure of the information is voluntary and that I am not obligated to sign this form to ensure healthcare treatment.

Signature of Patient or Legal Representative Date

If signed by a legal representative, relationship to patient: _____

Signature of Witness Date