Rheumatology Associates

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO: _____ _____

Name of person/physician/facility Fax number

By signing this authorization, I authorize Rheumatology Associates, P.A. to use and/or disclose certain protected health information (PHI) about me from the above.

Please fax the following individually identifiable health information about me to Rheumatology Associates, P.A. at 772-283-5538:

1. **All pertinent information**
2. **Office notes and recent labs**
3. **X-ray and imaging results**
4. **Bone Density results**

The information will be used or disclosed for the continuity of medical care.

This authorization will expire on: _____

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Rheumatology Associates, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the above address.

_____ _____

Signature of Patient or Legal Guardian **Date Signed**

_____ _____

Print Name of Patient or Legal Guardian **Date of Birth of Patient**