ARTHRITIS CONSULTANTS, PA
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ (Maiden) _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip Code _____

I hereby authorize and request that a copy of the following information from my medical record be released as follows:

FROM: _____ TO: _____

_____ _____

_____ _____

_____ _____

PLEASE CHECK INFORMATION TO BE RELEASED:

☐ Progress Notes ☐ Physician Orders ☐ Nurses Notes ☐ Directive to Physician

☐ X-Ray Reports ☐ Lab Reports ☐ Billing ☐ All of the above

☐ Other (Specify): _____

PURPOSE OF DISCLOSURE:

☐ Continued Patient Care ☐ Personal Use ☐ Second Opinion

☐ Attorney / Legal ☐ Commercial Insurance ☐ Worker's Compensation

☐ Social Security ☐ Other (Specify): _____

INCLUDING INFORMATION (IF APPLICABLE) PERTAINING TO:

☐ Psychiatry / Psychology ☐ Drug ☐ Alcohol ☐ HIV / AIDS

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person. I further understand that my medical records from other health care providers will not be released with this routine request. This consent will expire six (6) months after date of signature.

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Arthritis Consultants, PA liable for any misrepresentation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

I understand that I may revoke this authorization in writing at any time except to the extent AC,PA has already relied on this authorization. I understand that I may revoke this authorization by providing AC,PA with a written request for revocation stating my intent to revoke this authorization.

_____ _____ ____/____/____

Signature of Patient or Legal Representative Relationship to Patient Date

_____

Witness