GREENSBORO RHEUMATOLOGY, PA
2835 Horse Pen Creek Road, Suite 101
Greensboro, NC 27410
Telephone: 336-617-6568 Fax: 336-617-6660

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth:_____

Address: _____

Telephone:_____Social Security Number:_____

I hereby authorize the **Greensboro Rheumatology, PA** to release, disclose, and deliver my protected health information and all of my medical records to the following entity:

Name of Facility:_____

Address:_____

Telephone number:_____ Fax number:_____

Information to be released and disclosed:
History/Physical Labs Operative Notes Visit Summary Pathology
Discharge Summary X-ray Reports Other (please indicate)_____

The purpose of this release and disclosure is for my continued medical care.

I authorize **Greensboro Rheumatology, PA** to deliver this Authorization to Release Protected Health Information on my behalf to the above named entity by facsimile or other electronically transmitted means.

I understand that I may revoke this Authorization at any time. The revocation will not apply to information that has already been released in response to this Authorization. ***If I fail to specify an expiration date or event or condition, this Authorization will expire automatically one (1) year from the date of signature.*** If I revoke this Authorization, I must do so in writing and submit my revocation to the practice administrator for Greensboro Rheumatology, PA. I may refuse to sign this Authorization. Greensboro Rheumatology, P.A. will not condition my treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

Consent and Protection of Authorization: Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of such information. I understand that the information released may include sensitive information related to behavioral and/or mental health records, drugs and alcohol, HIV/AIDS and other communicable diseases, and genetic testing. It is possible that once disclosed the privacy of the information will no longer be protected under federal privacy laws.

Copy of Form: I understand that I will be given a copy of this Authorization form after signing.

I have read and understand this information in this Authorization form.

Patient or Patient Representative Signature_____ Date_____

Relationship of Authorized Patient Representative (if applicable) _____

Witness Signature (REQUIRED) _____ Date_____

[PATIENT IDENTIFICATION CONFIRMED BY WITNESS BY DRIVER'S LICENSE OR OTHER IDENTIFICATION]