AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Medical Records Request Form)

Patient Name: _____Date of Birth:_____

Address: _____

Telephone:_____SSN (last 4-digits only):_____

I hereby authorize the following entity to release, disclose, and deliver all of my protected health information and all of my medical records.

Name of Facility:_____

Address:_____

Telephone number:_____ Fax number:_____

Information to be released/accessed:

History/Physical Labs Operative Notes Visit Summary Pathology
Discharge Summary Diagnostic Imaging (X-rays, CTs, MRIs,) Other _____

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

Greensboro Rheumatology, P.A.
Suite 101, 2835 Horse Pen Creek Road
Greensboro, North Carolina 27410
Telephone number: 336-617-6568 Fax number: 336-617-6660

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 the information in this Authorization form

_____ _____
Signature of Patient Date

_____ _____
Signature of Authorized Representative (if applicable) Date

_____
Representative's Relationship/Authority to make request on behalf of patient (if applicable)

_____ _____
Witness Signature (**Required**) Date

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

Revision Date: 09/01/17