Low Country Rheumatology
"Working together, to make a difference"

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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Patient Name: _____ DOB: _____

Previous Name: (If applicable) _____

Social Security # _____

**** This authorization expires ONE year from the date of signature****

Method of disclosure:

[ ] release medical records **FROM** **Low Country Rheumatology to:**

Name: _____

Address: _____

Fax #.: _____

[ ] release medical records **TO** **Low Country Rheumatology from:**

Name: _____

Address: _____

Fax #: _____

Health Information to disclose:

[ ] ALL health information

[ ] Healthcare information relating to the following treatment, condition, or dates

_____

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date:

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____