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

Articularis HEALTHCARE

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Medical Information Release Form
(HIPAA Release Form)

Name: _____ DOB: _____

I understand that Low Country Rheumatology maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is **NOT** to be released to anyone

[ ] Check if okay to leave detailed health information on voicemail

Patient Signature _____ Date _____

Witness Signature _____ Date _____