RHEUMATOLOGY ASSOCIATES

Main Phone: 214-540-0700; Main Fax: 214-540-0701

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Rheumatology Associates** to use and/or disclose certain protected health information (PHI) about me to Dr. _____ at _____.

Patient's Name_____ Date of Birth _____.

This authorization permits **Rheumatology Associates** to use and/or disclose the following individually identifiable health information (IIHI) and PHI about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.), or all records [if not specifically described, all records will be sent]:

_____
_____.

The information will be used or disclosed for the following purpose:
_____, or ☐ at the request of the individual.

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this IIHI and PHI expires.

The information may include information about HIV, AIDS, alcohol use, drugs, and mental health.

I do not have to sign this authorization in order to receive treatment from Rheumatology Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 8144 Walnut Hill Lane, Suite 800, Dallas, Texas 75231

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

RHEUMATOLOGY ASSOCIATES

8144 Walnut Hill Lane, Ste. 800
Dallas, TX 75231
Main Phone: 214-540-0700; Main Fax: 214-540-0701

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Dr.**_____to disclose certain protected health information (PHI) about me to **Rheumatology Associates.**

Patient's Name_____ Date of Birth _____.

This authorization permits **Dr.**_____to use and/or disclose the following individually identifiable health information (IIHI) and PHI about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.), or all records [if not specifically described, all records will be sent]:

_____
_____.

The information will be used or disclosed for the following purpose:
_____, or ☐ at the request of the individual.

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this IIHI and PHI expires.

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I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION