arthritis CARE
RHEUMATOLOGY CARE | RESEARCH

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# Authorization to Release Protected Health Information

**(HIPAA Compliant Request for Information/Medical Records)**

I hereby give permission to Arthritis Care and Research Center, Inc (ACRC) to release my, below checked, Protected Health Information (PHI) also known as My Medical Records to:

*Be certain that information is accurate and complete.* ***Incomplete authorizations are invalid.***

_____
Name of Medical Office/Company/Entity you want ACRC to send records.

_____
Street Address

_____
City State ZIP Code

_____
Phone Number Fax Number

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☐ Release a copy of my entire chart including X-rays and lab reports

☐ Release records for this specific date of service_____

☐ Release specific information _____

I am requesting my PHI to be disclosed for reason_____

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*I understand the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.*

*I do not give permission for any other use or re-disclosure of this information.*

*I understand that this authorization will automatically expire one year from the date executed. I understand I may revoke this consent at any time in writing, except to the extent that action has already been taken.*

*I understand that I have a right to receive a copy of this authorization upon my request.*

**Patient Signature** _____ **Date** _____

**Witness Signature** _____ **Date** _____

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