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

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

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

_____
Street Address

_____
City State ZIP Code

_____
Phone Number Fax Number

☐ 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_____

I understand this information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I release you from all liability that may arise from your compliance with this request to release records.

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** _____

Please send My Records to:
Arthritis Care and Research Center, Inc
15644 Pomerado Road, STE 102
Poway CA 92064
FAX: 858-435-0207