

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Patient Full Name

Other Names?

Patient Address Apt # / P.O. Box # (please include complete mailing address)

Date of Birth (Month/Day/Year)

City State Zip Code

Phone #

THE UNDERSIGNED AUTHORIZES ARTICULARIS RHEUMATOLOGY SPECIALISTS TO OBTAIN INFORMATION FROM:

Facility Name

Phone #

Street Address

City State Zip Code

INFORMATION TO BE OBTAINED:

- Referral
- Progress Notes
- Recent Labs and Imaging Reports
- Demographics
- All of the Above
- Other _____

THE UNDERSIGNED AUTHORIZES ARTICULARIS RHEUMATOLOGY SPECIALISTS TO RELEASE INFORMATION TO:

Email Address (for record delivery)

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.

Facility Name

Attention

Street Address

Phone #

City State Zip Code Fax #

PURPOSE OF REQUEST:

- Personal
- Treatment
- Legal
- Insurance
- Transfer
- Other _____

INFORMATION TO BE RELEASED:

- Please release a **1-year abstract** of my records
(includes most recent notes, labs, procedures & testing)
- Please release a **2-year abstract** of my records
(office notes, labs, procedures & testing, up to 2 years)
- Date Range: _____
- Progress Notes
- Radiology Reports
- Labs
- Operative Reports
- Injections
- Physical Therapy
- Other _____

If you fail to specify, a 1-year abstract will be provided.

PLEASE PICK ONE DELIVERY OPTION:

- Send by Email
- Fax to Doctor
- Records on Paper
- Records on CD

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed South Carolina's Statute: (44-115-80)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, _____
HIV testing, HIV results, or AIDS information.* Please Initial

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**

_____ If I do not specify expiration this authorization will expire in 90 days.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

PLEASE CONFIRM THAT YOU HAVE FILLED OUT THIS FORM IN ITS ENTIRETY—IF FORM IS INCOMPLETE, OR IF PROTECTED INFORMATION IS NOT RELEASED; WE MAY BE UNABLE TO FULFILL THIS REQUEST.

Signature_____
Date