The Center for
RHEUMATOLOGY LLP
Diagnosis, Care and Research

HIPAA Release Form

PATIENT'S FULL NAME: _____ DOB: _____

By signing this authorization, I authorize the Center for Rheumatology, LLP to use and / or disclose certain protected health information (PHI) about me to the following individual(s) or organization(s):

- _____ relation: _____
- _____ relation:_____
- _____ relation: _____

1. Name and phone number of your emergency contact: _____

2. Do you give our office permission to leave you a detailed message? _____ yes _____ no

If we must leave a detailed message, please check the preferred method of contact:

□ Home phone □ Cell phone □ Work phone

3. Please initial:

_____ I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV-REALATED INFORMATION unless I exclude this information above. In the event my PHI includes any of these types of information, I specifically authorize release of such information to the person(s) entity(ies) listed above.

4. Duration of Authorization: This authorization to share my PHI is valid (check one of the below):

□ a) From Start Date _____ to End Date _____.

□ b) All past, present, and future periods OR

□ c) The date of the signature below until the following event _____.

5. Do you authorize the office to send your medical records via encrypted email upon request?

□ YES □ NO If YES email to receive electronic records _____

6. The patient portal is the most convenient method for patient access to medical records, imaging results, lab results and visit summaries. Would you like to opt-in to patient HIPAA secure patient portal? □ YES □ NO
Notifications of new information to your patient portal should be sent to the following email address if not listed above

Email: _____

I understand that The Center for Rheumatology, LLP will not receive payment or other renumeration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization to receive treatment from The Center for Rheumatology, LLP. 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 HIPAAA 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 attention of my personal physician.

Printed Name of Patient or Legal Guardian _____
Signature of Patient or Legal Guardian:_____
Relationship to Patient:_____ Date: _____