RHEUMATOLOGY ASSOCIATES, P.A.

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Authorization for Release of Protected Health Information

To: _____ **Records needed:**
_____
_____

I authorize you to release any and all medical records in your possession concerning my treatment to Rheumatology Associates, P.A., Dr. _____

Patient's Name: _____

Date of Birth: _____

I understand that my treatment at Rheumatology Associates, P.A. is not contingent upon my signing this authorization and I understand that I have the right to revoke this authorization at any time, by delivering my written notification directly to the practice or by mailing it to the Privacy Contact Person, Gay Nelson, 14E Farmfield Avenue, Charleston, SC 29407. I understand that Rheumatology Associates, PA may have already acted upon my authorization and can only agree to discontinue.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- **Inspect or copy the protected health information to be used or disclosed as permitted under federal law.**
- **Refuse to sign the authorization.**

_____ **_____**
Signature of Patient or Personal Representative **Date**

_____
Print Name of Patient or Personal Representative