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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 Advanced Arthritis Clinic

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

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

_____
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 _____