Low Country Rheumatology

A MEMBER OF Articularis HEALTHCARE

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Authorization to Release/Obtain Medical Records

Patient Name:_____ DOB: _____

Previous Name (if applicable):_____ SSN: _____

* ***This authorization expires ONE year from the date of signature****

Method of disclosure:

☐ I authorize Articularis Healthcare to **release** my medical records to:

Name: _____

Fax #: _____

☐ I authorize Articularis Healthcare to **obtain** my medical records from:

Name: _____

Fax #: _____

Health Information to disclose:

☐ ALL health information

☐ Healthcare information relating to the following:

Treatment, Condition, or Dates: _____

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date:

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____