

PATIENT AUTHORZIATION FOR SPECIFIC USE AND DISLOSURE OF PROTECTED HEALTH INFORMATION

**(TO GIVE FAMILY MEMBER(S)/GUARDIANS(S) ACCESS TO RECORDS)**

By signing this authorization, I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to discuss certain protected

**NAME OF FAMILY MEMBER OR GUARDIAN**

health information about me to WEST COUNTY RHEUMATOLOGY.

The purpose of this information will be used for continued care.

WEST COUNTY RHEUMATOLOGY will not release requested health information to a third party.

I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subjected to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I understand that unless I specifically request that such information not be disclosed, authorized disclosures may contain Protected Health Information obtaining diagnosis, treatment and other information regarding psychiatric and mental health, substance abuse (chemical dependence), HIV, and/or AIDS.

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 entity disclosing my medical records, listed above.

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Patient Name (Last, First, MI) Date of Birth Social Security Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_

Patient/Legal Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Printed Name Phone Number

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Street Address, City, State, Zip Code