

PATIENT AUTHORZIATION FOR SPECIFIC USE AND DISLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize West County Rheumatology to disclose certain protect health information about me to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of recipient Street, Suite, City, State, Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of recipient Street, Suite, City, State, Zip Code

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Name of recipient Street, Suite, City, State, Zip Code

I have the right to refuse signing this authorization. West County Rheumatology does not release information provided by other entities. Only information that has been generated by West County Rheumatology will be disclosed. I understand that unless I specifically request that such information not be disclosed, authorized disclosure may contain protected health information containing 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 Privacy Office of West County Rheumatology.

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

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Patient/Legal Guardian Signature Date

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

Patient/Legal Guardian Printed Name Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address, City, State, Zip Code

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Witness