

**West County Rheumatology HIPAA Authorization Form**

I authorize West County Rheumatology to use and disclose the protected health information described below to all other providers involving in my care including but not limited to

Primary Care Physician:

Specialists:

Specialists:

Specialists:

I authorize the release of my complete medical records: Labs, Radiology , HIV or AIDS , psychiatric history and progress Notes. This medical information may be used by West County Rheumatology for medical treatment or consultation, billing or claims payment.

Signature of Patient Date:

Printed Name Date: