

**GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZED FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: _____ SS #: _____
 First Name MI Last Name

Date of Birth: _____ Address: _____

Home Phone: _____

I authorize the disclosure/release of the following information: (check all that apply)

- All records
 - Laboratory/Pathology/X-Ray records
 - Other
-

Please send the records listed above:

From: _____

To: Gulf Coast Rheumatology

Physician Name: Adam Grunbaum, D.O., F.A.C.R.

Phone: (727) 940-9391

Address: 9332 State Road 54, Suite 209, Trinity, FL 34655

Fax: (727) 937-4003

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature: _____ Date: _____

Printed Name: _____