Howard Rheumatology **8763 E Bell Road, Suite #102**
Scottsdale, AZ 85260

HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH RECORDS

This form is for use when such authorizations is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following treatment or condition.

- All of my health information
- Last two office visits, last two labs and last DEXA scan
- My health information relating to the following treatment or condition:

_____

The above party may disclose this health information to the following recipients:

Name (or title) and organization Howard Rheumatology PLLC

8763 E Bell Road, Suite #102

Scottsdale, AZ 85260

Please send via Fax: 929.361-2255 or Email : front.desk@howardrheumatology.com

The purpose of this authorization is at my request

This authorization ends:

Date: _____

My Rights:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that users can disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____