Rheumatology Associates, P.C.
8902 N. Meridian Street, Suite 210
Indianapolis, IN 46260
Phone: 317-844-6444
Fax 317-848-6605

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize ____
Dr.'s Address: ____
____

to release the following information from the health records of:

____ ______________
(Print patient name) (DOB)

____
(Patient address) (City, State, Zip)
Social Security Number: ____________________________

Information to be released to: ____
Address: ____
____

Purpose of disclosure: ____

***I authorize the release of any and all medical records and reports concerning my medical history, physical condition, diagnosis, treatment and/or prognosis, including x-rays and other diagnostic reports, as well as any information contained in my medical records or reports that relates to treatment and/or history of psychiatric or mental health problems, drug or alcohol abuse problems, dangerous communicable diseases, including AIDS or tests for infections with HIV, and any other information related to my treatment.

This release shall apply to any and all data listed above unless otherwise indicated by the patient as follows:
Information to be released:

_______ Copy of complete health record(s)
_______ History and Physical
_______ Other ________________________________
_______ Bone density report(s)
_______ X-Ray report(s)
_______ Lab report(s)

Do not release information contained in my record regarding: ______________________
____

Release only my records for the dates of _____________ through _____________.

I understand this consent can be revoked in writing at any time to Rheumatology Associates, P.C. except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Rheumatology Associates, P.C. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to 1) Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), 2) Refuse to sign this authorization, 3) Receive a signed copy of this authorization.

This authorization is valid for sixty (60) days after the date this request is made and/or for the length of the pending claim, unless otherwise stated as follows ___________________________

Patient's Signature____Date________________
(Or signature of legal representative if patient is a minor or incompetent)