Carolina Arthritis Associates, PA
Authorization to Release Health Information

Patient Information

Full Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip_____Phone_____

At my request_____ ___may release the following information:
(Name of the entity)

___ Entire record ___ Financial records ___ Office visit notes

Entity or person who will receive the information:

Name _____

Address_____

City, State, Zip_____Phone_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

Signature of Patient (or Personal Representative) _____

Date _____

Description of Personal Representative's Authority (attach necessary documentation)

_____

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