CRD
Clinic for Rheumatic Diseases
4280 Watermelon Rd, Suite 112
Northport, AL 35473
(205) 750-0030/ (888) 750-3050 PHONE
(205) 750-0855 FAX

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

Patient Name _____

Patient's DOB _____

Patient Address _____

Patient's Phone # _____

City, State, Zip _____

Persons/Facility providing medical records

Name: _____

Address: _____

City, State, Zip _____

Phone: _____

Fax: _____

Persons/Facility receiving medical records

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Northport, AL 35473

Phone: (205) 750-3050 Fax: (205) 750-0855

Attn: _____

The type of information to be used or disclosed is as follows, please provide dates of service:

____Clinic Notes (_____to _____)

____Radiology Reports (_____to _____)

____ Billing Records (_____to _____)

____Lab Reports (_____to _____)

____ Medication List (_____to _____)

____Other

If Other, Please specify:

_____

Purpose of Use or Disclosure

_____ Personal records

_____ Sharing with other healthcare providers

_____ Other (please describe)

_____

1. I understand that the information in my health record may include information related to drug and/or alcohol abuse/treatment, behavioral or mental health services, or records pertaining to sexually transmitted diseases, if they are part of my record.
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, and that it will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient or Legal Representative _____ Date _____

If signed by Legal Representative, Relationship to Patient _____ Date _____

Signature of Witness _____

This authorization will expire 12 months from the date of signature