AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT RIGHTS

The patient has a right to confidentiality of their personally identifiable health information. They also have a right to share their personal health information. They may extend this privilege to a family member or other designated person by a written authorization that will be kept on file by ***Northwest Rheumatology Specialists***. This agreement shall remain in effect until revoked by the patient or their power of attorney (POA).

Patient's Name:____DOB: ___________________

Phone #: __________________________Address:____

City, State, Zip:____

Information to be share:

- ☐ Laboratory results
- ☐ X-Ray Results
- ☐ Examination results
- ☐ Prescription Drug Information
- ☐ Plan of Care
- ☐ Demographic information; including address, birth date, phone, social security number, etc.
- ☐ All the above
- ☐ Other: ____

I understand that my signature will allow physician/staff members of ***Northwest Rheumatology Specialists*** to provide the above information to another person authorized by me. I authorize the release of the above information to:

Name of authorized individual:____

Telephone number of Authorized Individual: ____

Relationship to Patient: ____

Address: ____

I authorize the release of my personal health information as indicated on this form to the individual identified above. This authorization is good until revoked by myself or my POA.

Signature of Patient: ____ Date: _____________

Witness: ____ Date: _____________