



HIPAA PATIENT AUTHORIZATION AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Patient Name _____ Today's Date _____ ^{Date of Birth} _____ / _____ / _____
Month / Day / Year (xxxx)
Primary Contact Number _____

ALTERNATE CONTACT NUMBERS

If we cannot reach you at the primary number above, we may contact you (including leaving messages) at:

_____ **Business Number** _____ **Cell Phone Number** _____ **Other Phone Number**

PERSONS AUTHORIZED TO RECEIVE INFORMATION

I authorize Southeastern Rheumatology Alliance (SERA) to disclose my Protected Health Information (PHI) to the following individuals:

_____ Name	_____ Phone Number
_____ Name	_____ Phone Number
_____ Name	_____ Phone Number

INFORMATION TO BE DISCLOSED

Complete Medical Records **Specific** Records (describe below)

AUTHORIZATION STATEMENT

I understand that the PHI disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to revoke this authorization at any time by providing written notice to Southeastern Rheumatology Alliance (SERA), except to the extent that action has already been taken. I understand I am not required to sign this authorization as a condition for treatment unless the sole purpose of the treatment is to create health information for a third party. I will be provided a copy of this authorization.

_____ **Signature of Patient or Patient's Legal Representative** _____ **Month / Day / Year**

_____ **Printed Name of Patient or Legal Representative** _____ **Relationship to Patient**

EXPIRATION DATE OF AUTHORIZATION

Indefinite until revoked in writing Expires on (MM/DD/YYYY):

_____ / _____ / _____