Buckhead Rheumatology

Release of Information

Patient Name: _____

Patient Date of Birth: _____

I authorize Buckhead Rheumatology to release medical information to my referring doctor, health agency, government agency, insurance company, laboratory, pharmacy, hospital or medical facility.

I authorize any physician, hospital or clinic to provide details of medical history to Buckhead Rheumatology.

With this consent, Buckhead Rheumatology may call and leave a message on my cell, work or home number in reference to appointment reminders, insurance items, and clinical care.

Medical information can be disclosed to the following persons:

Name: _____ Phone Number_____

Name: _____ Phone Number_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected. I understand that the specified information to be released may include but it is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. The authorization will expire in one year from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____

Signature: _____