RHEUMATOLOGY CARE CENTER

Patient Name: ____

Date of Birth: _______________

Any physician, staff, employee or representative of Rheumatology Care Center, LLC has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)

Also, I hereby authorize Rheumatology Care Center personnel to leave messages regarding lab results, appointment information, and treatment information on the following telephone voicemail boxes:

1) ____

2) ____

3) ____

I understand that authorizing the release of my information to the above individual(s)/voice mail(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Rheumatology Care Center, LLC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: ____Date: ____________________