ADVANCED RHEUMATOLOGY

4202 Collins Rd, Ste 115, Lansing, MI 48910
Phone: 517.908.3600 Fax: 517.908.3601
Monika Mohan, MD, MPH

Authorization for Release of Protected Health Information (HIPAA Compliant)

Patient's Full Name: _____ Date of Birth: _____

I authorize the use and disclosures of the above-named individual's health information as described below:

TO → ADVANCED RHEUMATOLOGY
Address: 4202 COLLINS RD, STE 115
LANSING, MI 48910
FAX #: (517) 908-3601

FROM → _____
Address: _____
_____
FAX #: _____

The type of information to be disclosed includes (but is not limited to):

- office notes
- patient history
- physical exam notes
- consultation notes
- ER treatments
- clinical reports
- inpatient notes
- discharge summaries
- questionnaires
- test results
- X-rays & imaging
- lab results

You may list a specific date range or specific tests for disclosure
Please list that information (if any) here: _____

State and Federal Laws protect the following information. If applicable, please check any or all of the information you would like WITHHELD from the released records:

☐ Psychiatric treatment ☐ HIV treatment ☐ Alcohol or drug abuse treatment records

The information for which I am requesting disclosure will be used for the following purpose ***(check all that apply):***

☐ My personal use ☐ Evaluation for life insurance coverage ☐ At the request of my attorney
☐ Insurance ☐ Eligibility evaluation for disability ☐ New /Other Physician's Office
☐ Other (please describe): _____

- I understand I have the Right Not To Sign. I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment by Advanced Rheumatology, PC, except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
- In understand I have the Right To Revoke. I may revoke this authorization at any time. My revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, I must submit a written revocation to the following address: 4202 Collins Rd, Ste 115, Lansing, MI 48910.
- I understand that once the information listed above had been disclosed, it may re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

Expiration date or event for this authorization of release *(if any)*: _____

I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described.

_____
Signature of Patient or Personal Representative Date

_____
Name of personal representative *(if applicable)* Relationship to patient