



Rheumatology Consultants
Klein & Associates, MD, PA

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Arthritis and Rheumatic Diseases • Connective Tissue Diseases • Osteoporosis • DXA Scanning for Bone Density • Clinical Drug Trials

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider subject to the federal privacy regulations, the released information may no longer be protected by federal privacy regulations and that it may be re-disclosed by the recipient without my knowledge or permission.

**If this authorization is for marketing purposes, remuneration is / is not involved (Provider circle one).

Please release medical records of _____ Date of birth _____

FROM / TO (circle one) Klein & Associates, MD, PA

TO / FROM: _____

Street	City	State	Zip Code
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Specific description of information to be disclosed (The following information cannot be disclosed without specific authorization: psychotherapy notes, information regarding HIV, mental health, alcohol or drug abuse):

Information to be released: _____

Purpose of disclosure: _____

Dates of the records that you are requesting: _____ (DD/MM/YY)

You must read and initial the following statements:

- I am entitled to a copy of this authorization. Initials: _____
- I understand this authorization will expire one year from date of signature. Initials: _____
- I understand that I may revoke this authorization by notifying Klein & Associates in writing, but if I do, it will not have any effect on any actions Klein & Associates took before they received the revocation. Initials: _____

Signature of patient or Representative

Relationship to patient

Date

**You may refuse to sign this authorization.
We cannot condition treatment, payment or other benefits on your signing this authorization.**