Medical Release Form

Patient Name | **Middle Name** | **Last Name** | **Birthday**

Requested From:

Person/Organization | **Address** | **City** | **State**

Zip | **Phone #** | **Fax#**

Send Information To:

ACHYJOINT

26103 I-45 STE 100

The Woodlands, TX 77380

Phone: (281) 406-0484

Fax: (833) 707-2376

I authorize the release of my health information for the following specific purpose:

- ☐ Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ Employment
- ☐ Other

I authorize the release of the following health information:

Options

- ☐ Recent Labs
- ☐ Last Rheumatology Clinic Note
- ☐ Entire Medical Record
- ☐ Autoimmune Serologies
- ☐ MRI Report
- ☐ Procedure Report
- ☐ Infusion Note
- ☐ Progress Note
- ☐ Pathology Report
- ☐ Surgery Note
- ☐ EMG report
- ☐ Hand Xrays
- ☐ Foot Xrays
- ☐ Knee Xrays

Other

Terms of Authorization:

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 no longer protected. I understand that the specified information to be released **may include, but is not limited to: history, diagnoses and/or treatment of drug or alcohol abuse, mental illness or communicable disease including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).** I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. 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 the authorization.

Effective Time Period: This authorization is valid; This authorization is valid until the earlier of the occurrence of the death of the individual; or permission is withdrawn in writing and received by Acclaimed Rheumatology & Wellness Center PLLC.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Right to revoke: I understand I can withdraw my permission at any time given written notice stating that my intent to revoke his authorization to the person organization named under "Who Can Receive And Use Health Information" I understand that prior actions taken in lines on this authorization by entities to have permission to access my health information will not be affected.

Patient/Representative Signature

Patient Name

Middle Name

Last Name

Name of Legal Guardian

Legal Relationship

If Individual is unable to sign this Authorization, please list legal guardian name and relationship.

PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED AS VALID AS THE ORGINAL