HIPAA Authorization for Disclosure of Protected Health Information

(As required by the Health Insurance Portability and Accountability Act – 45 CFR parts 160 and 164)

Piedmont Arthritis Clinic

3 St. Francis Drive, #400, Greenville, SC 29601
ph: 864-235-8396 fax: 864-271-4092

Patient Name: _____ Date of Birth: _____ Medical Record #: _____

By signing this form, I hereby authorize PIEDMONT ARTHRITIS CLINIC to disclose protected health Information, as described below, to the following individual or organization:

Person or facility to receive health information: _____

Street Address: _____ Phone: _____

City/State/ZIP: _____ Fax: _____

Time Period for Release of Records:

- ❑ All past, present, and future periods
- ❑ From _____(insert date) to _____(insert date)

Information to be released:

- ❑ Medical Records (including office and procedure notes, test results, and radiology studies)
- ❑ Entire Chart (including office and procedure notes, test results, radiology studies, referrals, consults, billing records, insurance records, and records sent to Piedmont Arthritis Clinic from other healthcare providers)
- ❑ Specific Records:
  - ❑ Office and Procedure Notes
  - ❑ Lab Results
  - ❑ Radiology Results
  - ❑ Billing Records
  - ❑ _____

Reason for release of information: ❑Treatment ❑ Self ❑ Transfer of Care ❑ Other_____

Date or event on which this authorization will expire: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not in effect until Piedmont Arthritis receives it, to the extent that any person or entity has already acted in reference to this authorization.

_____ _____

Signature of Patient or Authorized Representative Date