Advanced Rheumatology of Houston

Authorization for Disclosure of Confidential Information

Houston
17115 Red Oak Drive, Suite 210
Fax: 281-719-9320

Woodlands
6767 Lake Woodlands Drive
Fax: 281-719-9320

Patient Name_____

Address_____

Date of Birth_____SSN_____

Authorizes: Name of Person/Facility_____

Address or Fax Number_____

To release the following medical information to **Advanced Rheumatology of Houston.**

Check All that May be released:

□ History □ Lab Reports □ Operative Report □ Psychological Reports

□ Physical □ X-ray □Care Plan □ Progress Notes

□ EKG Report □ Therapy Reports □ Other (specify)_____

Note: Memorial Hermann patients mus initial the following statement:
"I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV Testing, HIV results, or AIDS information" INITIAL HERE_____

This authorization covers patient care rendered from _____ to _____ (dates)

Purpose of Disclosure:

□ Medical Care □ Insurance □ Attorney □ Other (specify)_____

The authorization shall be valid for ninety (90) days from the date of signature below, unless revoked in writing by the patient prior to that expiration.

The patient agrees that a photocopy of this authorization may be considered valid.

□ Yes □ No

Patient Signature:_____Date:_____