Rheumatology Care Specialists

30 LaCrue Avenue, Ste 101

Glen Mills, PA 19342

Phone: 610-558-4800; Fax: 610-558-4844

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM:

RHEUMATOLOGY CARE SPECIALISTS

Name of Client/ Patient: _____

(Patient's full name: Please PRINT)

Date of Birth: _____/_____/_____ **SSN:**_____

I hereby request and authorize: Rheumatology Care Specialists

30 LaCrue Avenue, Ste 101, Glen Mills, PA 19342 Phone Number : 610-558-4800

To release records to: _____

(Name of Physician or Practice)

_____

(Agency Address) (Telephone & Fax Number)

the following type(s) of information for my records(and any specific portion thereof):

_____

Including those pertaining to HIV treatment

For the purpose of : Continuation of Care

All information I hereby authorize to be obtained for this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

____ ninety (90) days unless I specify an earlier expiration date here: _____

____ one (1) year

____ the period necessary to complete all transactions on account related to services provided to me

I understand that unless otherwise limited by state or federal regulation and except to the extent

_____ _____

(Signature of patient/client) (Date)