

**Rheumatology Care Specialists**

30 LaCrue Ave, Ste 101, Suite 101  
Glen Mills, PA 19342

200 Old Forge Ln, Ste 203  
Kennett Square, PA 19348

Phone: 610-5558-4800 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

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)