Arthritis and Rheumatology of Georgia
A Division of Articularis Healthcare Group, Inc.

Patient Authorization for Use and Disclosure of Protected Health Information

Articularis HEALTHCARE

This information is used to facilitate our communications with you as we strive to provide you with excellent service.

Patient Information *(please print clearly)*:

_____ _____
Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____ _____
Street Address *Apt #/P.O. Box # (Please include complete mailing address)* *Medical Record Number/SSN*

_____ _____
City *State* *Zip Code* *Primary Contact Number*

If we cannot reach you at the telephone number listed above, Low Country Rheumatology may contact you (including leaving messages) regarding appointments or normal lab results at the following number(s):

_____ _____ _____
Business Number *Cell Phone Number* *Other Phone Number*

I authorize Arthritis & Rheumatology of Georgia to disclose Protected Health Information to the following persons:

☐ Spouse: _____
Name *Phone Number*

☐ Child(ren): _____
Name *Phone Number*

_____
Name *Phone Number*

☐ Other: _____
Name *Phone Number*

Information to be disclosed:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the Low Country Rheumatology location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that Low Country Rheumatology cannot require me to sign this authorization as a condition of treatment unless the provision of health care by Low Country Rheumatology is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature/Date: *(date authorization signed by patient or Legal Guardian/Personal Representative)* _____
Month/Day/Year

_____ _____
Print Patient Name or Name of Legal Guardian/Personal Representative *Signature of Patient or Legal Guardian/Personal Representative*

_____
Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.* *Last Updated: 1/27/2020*