23215 Commerce Park, Suite 318
Beachwood, OH 44122
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (First, Middle, Last): ______________________________ Date of Birth: ______________________

Telephone Number:____

Current Address:____

____

I hereby authorize CarePoint Rheumatology and Specialty Infusion Center to:
Check one: ☐Release my medical information to: ☐Obtain my medical records from:

Name:____

Address:____

____

Purpose for Disclosure:____
(Purpose for disclosure must be completed prior to processing. e.g., continuing care, personal use, legal)

The following medical Information regarding my care and/or treatment on the following dates:
Dates of service to release (Required) (FROM):___________________ (TO):__________________________

☐ All Records ☐ Patient Demographics ☐ Laboratory Reports ☐ Insurance Plan Information
☐ Infusion Treatment Protocol ☐ Immunizations ☐ History and Physical
☐ Other, please specify:

I understand and acknowledge that this Authorization extends to all or part of the records designated above. understand that I may revoke this Authorization at any time after I have signed it by providing CarePoint Rheumatology and Specialty Infusion Center with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my medical information can no longer be disclosed pursuant to this Authorization except to the extent that disclosures have already been made in reliance upon this Authorization.

Authorization is valid for one year, unless an earlier date or condition/event Is specified here: ________________________or unless revoked by me in writing before the release of the above designated information.

___________________________________ ________________________

Signature of Patient (or Patient Representative) Date

If this Authorization is signed by a legal representative of the patient (for example, the parent *or* legal guardian if the patient is a minor) a description of such representative's authority to act for the patient must also be provided (explain your authority to sign for the patient below). Except for legal representatives acting in the capacity as a parent to the patient, also attach a copy of documentation giving you the authority to sign this Authorization on behalf of the patient.

____________________________ ____________________________

(Name) (Relationship to Patient)

**For records covered by 42 CFR Part 2: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules Prohibit *you* from making *any* further disclosure of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.