RHEUMATOLOGY
ASSOCIATES

Name _____
Cell # _____
E-Mail _____

Receipt of Notice of Privacy Practices

I, _____, have received a copy of Rheumatology Associates' Notice of Privacy Practices.

_____
Patient Signature

Patient Request Regarding Health Information Release

(Friends/Family only – Not physicians)

Who to Contact

By completing and signing this document I hereby give permission to Rheumatology Associates to disclose as well as discuss any Protected Health Information related to my medical condition(s) with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- ☐ **I do not wish to give access to my Protected Health Information to anyone besides myself regarding my medical condition**

How to Contact
Note that you are responsible for any charges incurred in receiving our communications.

Alternate Form of Communication:

_____

_____
Patient Signature Date

RHEUMATOLOGY
ASSOCIATES

Legal Representative

If the patient has a legal representative who will be signing these forms for them please fill out the information below.

_____	_____
Legal Representative Name	**Legal Representative Signature**
_____	_____
Legal Representative E-Mail	**Legal Representative Cellphone #**