Sandhills Rheumatology
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Authorization for Release of Medical Records

I, ______________________________, hereby authorize Sandhills Rheumatology to release/receive my medical information to

______________________.

Information to be released:
- **Entire Medical Record** __________
- **Office Notes** __________
- **Labs** __________
- **Radiology Reports** __________
- **DEXA** __________

I understand that any information, including drug use, alcohol abuse, psychiatric condition and/or communicable diseases will be released as part of my records. I understand that I may, at anytime, revoke this authorization, but revocation will not apply to any records that have already been released. I understand that a COPY or FAX of this document is valid as an original document and that this authorization will expire in 90 days from signature date.
Purpose: Continuity of Care

Signature:_________________________ **Date:**______________
Patient SSN:________________________
Patient DOB:________________________
Provider:___________________________
Phone:______________________ **Fax:**____________________

- **You have the right to know specifically what information you are authorizing for release** ***(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").***
- **You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information** ***(e.g., the names of your health care provider(s)).***
- **You have the right to know who is going to use it and what it is going to be used for.** ***(e.g., John Smith, PhD / Research).***
- **You have the right to alter this request. We have preprinted options for your convenience. You may alter these items if needed.**
- **You have the right to receive a copy of this form**