Coastal Arthritis and Rheumatism Associates

David D. Fraser, MA, MD, FACP, FACR

Authorization for Use or Disclosure of Health Information

Patient Name: _____
[Print or type]

Patient's Date of Birth: _____ Patient's Identification/Chart No.: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific Description of the Information to be Used or Disclosed Including (If Practicable) the Dates of Service(s) related to Such Information:

All health related activities including the providing, coordinating, and managing of medical treatment. All insurance payment related activities so Coastal Arthritis may bill and collect payments from your insurance companies. All activities related to disability and insurance forms such that we may complete these for you in an efficient manner.

The above information will be called "Authorized Information" throughout the rest of this form.

Persons or Class of Persons Authorized to Make the Use or Disclosure of Authorized Information:

Any employee from Coastal Arthritis under direction of Dr. David Fraser.

Persons or Class of Persons to Whom the Use or Disclosure of Authorized Information May be Made:

See above under Specific Description.

Authorized Information will be used and/or disclosed for the following purposes:

[x] At the request of the individual (check box if applicable)
[ ] Other *(Please list each purpose of the use(s) or disclosure(s) in the space provided.)*:

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

- I understand that I may revoke this authorization at any time by notifying Coastal Arthritis and Rheumatism Associates, PA. in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Coastal Arthritis and Rheumatism Associates, PA. before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan, or eligibility for benefits.
- I understand that Coastal Arthritis and Rheumatism Associates, PA. may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that Coastal Arthritis and Rheumatism Associates, PA. will not provide such research-related treatment unless I provide this authorization.

This authorization expires at the earlier of five years from today's date OR with written revocation from the patient.

Signature of Patient or Patient's Personal Representative: _____

Date: _____

For Personal Representative of the Patient (if applicable):

Print Name of Personal Representative: _____

Describe Personal Representative Relationship/Authority to Act for the Individual (parent, guardian, etc.): _____