Lancet Rheumatology and Sara Lupus Clinic, PLLC

Patient Name: Date of Birth:

Address: Apt or Suite:

City: State: Zip Code:

Lancet Rheumatology & Sara Lupus Clinic, PLLC is authorized to disclose protected health information as described below.

Check each that is subject to this authorization:

- ☐ May leave information on my answering machine/voice mail.
- ☐ May call my workplace to contact me. Work #: _____
- ☐ May give verbal/electronic info for a prescription request.
  Preferred pharmacy: _____
- ☐ May release information necessary to complete requested forms for disability, FMLA, insurance, etc..
- ☐ May release information necessary to complete requests for handicap parking tags for DMV.
- ☐ Other, as described _____

Enter the name, date of birth, relation & phone number of each person you authorize to release information. ***Check*** all boxes that apply. These persons may contact our office for information about you.

- **Test/Scans:** Release test results (scans, labs, pathology, etc.)
- **Rx:** Allow this person to pick up written prescriptions at the office
- **Appt Info:** Release information about appointments (date, time, with whom and reason)

Name	DOB	Relation	Phone #	Test/ Scans	Rx	Appt Info
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending a written notification.

I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this with written notification to the above named persons.

I understand that my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

Signature (Patient or Representative): _____ Date: _____

Print Name (Patient or Representative): _____

Relation to patient, if Representative: _____