EARC

Medical Records Request Form

Request ___X___ Requesting information from another provider to us (Continuation of Care)

Date: _______________________

Name: ____ Phone: ___________________________

Date of Birth: ________________________________ SS#: _____________________________________

Address: ____

City: ______________________________________ St: __________ Zip: _______________________ I authorize East Alabama Rheumatology Center to *request* from:

Facility Name: ____

Physician: ____

Address: ____

Fax: ____

Information Requested : **Complete Medical Record** Other: ______________________________________

Release information to:

East Alabama Rheumatology Center , a service of East AL Medical Center.

2000 Pepperell Parkway, Building 5

Opelika, Alabama 36801

FAX - 334/ 528-6628

- I understand that this authorization shall be valid through _____________ *(date),* but that I may revoke it **in writing** at any time: any such revocation shall have no effect on disclosures made previously. *(Valid for one year if not completed)*
- I understand that this health information may include information regarding drugs and alcohol / human immunodeficiency virus (HIV) test results. • I understand that, upon request, I may receive a copy of this authorization form after I sign it.
- I understand that I have the right to inspect the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.

Signature ____ Date ______________________________

Witnessed by ____ Date ______________________________