Emkey
Arthritis & Osteoporosis Clinic
Comprehensive & Compassionate Care

# Authorization for the Disclosure of Protected Health Information

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual reserves the right to revoke the Consent. At all times, such revocation must be submitted to Emkey Arthritis & Osteoporosis Clinic in writing.

I authorize the release of all medical records to the referring or primary care physician as required for treatment and to my health insurance company, and if applicable, I authorize my health transmission of medical information by fax.

Patient Name: _____ Date: _____

Address: _____

Date of birth: _____/_____/_____ Social Security #: _____

Email Address: _____

**Phone Numbers:**

Home: _____; Emkey Arthritis may leave a voice message with clinical information: YES or NO

Work: _____; Emkey Arthritis may leave a voice message with clinical information: YES or NO

Mobile: _____; Emkey Arthritis may leave a voice message with clinical information: YES or NO

**Emkey Arthritis may discuss any portion of my medical record with the following individuals. I understand this authorization will be in effect until which time it is revoked.**

Name _____ Relationship_____ Phone#: _____

Name _____ Relationship_____ Phone#: _____

Name _____ Relationship_____ Phone#: _____

**Emkey Arthritis is authorized to disclose health information (by fax, if applicable) about me for treatment, payment and healthcare operations purposes with its notice of privacy practice.**

Signature of Patient, Guardian or Responsible Party: _____

Printed Name: _____ Date _____