MARIETTA Rheumatology ASSOCIATES P.C.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: (Provider or Facility Name)

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Patient Name: __________________________________

DOB: ________________________________

I, the undersigned, authorize the release of any and all medical information pertaining to me that are in your possession for the purpose of medical treatment. Including but not limited to HIV test results and AIDS information, psychological, psychiatric, alcohol and drug abuse, vocational records.

Please release my records to **Marietta Rheumatology Associates, P.C.** at the above address or secured fax number:

I further authorize that a copy of this medical authorization may be used in lieu of the original. I also understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

X____
Sign Patient or Representative Date

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Name of Patient or Representative (Print)

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Relationship to Patient