RHEUMATOLOGY CENTER OF SAN DIEGO

9850 Genesee Ave., Suite 560, La Jolla, CA 92037 • 215 S Hickory St., Suite 114, Escondido, CA 92025

Tel (858) 336-2810 • Fax (949) 798-7990

Patient Name: _____ DOB: _____

Form and Letter Fee

Our fee for forms and letters is $50 (fifty dollars). Forms include, but not limited to FMLA, disability, motor vehicle division, San Diego Metropolitan Transit System, continue of pay, payment of car loans, payment of mortgages, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agents, gyms, etc.

In order to comply with federal laws including HIPAA, as well as California state and federal statues, our office must have a signed authorization from the patient or responsible party stating who we are authorized to release information to.

_____ _____

Signature of patient or responsible party Date

Patient Authorization for Use/Disclosure of Protected Health Information (PHI)

SSN: _____ Previous Name: _____

I request and **authorize** Rheumatology Center of San Diego PC to release healthcare information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip code: _____

This request and **authorization** applies to:

□ Healthcare information relating to the following treatment, condition, or dates of treatment:

_____

□ All healthcare information

□ Other:

_____

_____ _____

Signature of patient **or** patient's authorized representative Date signed