Rheumatology Consultants
Klein & Associates, MD, PA
Steven J. Klein, MD, FACR
Board Certified Specialist in Rheumatology

Mary P. Howell, MD
Devin Traynor, PA-C
Theresa Gillis, PA-C

Arthritis and Rheumatic Diseases • Connective Tissue Diseases • Osteoporosis • DXA Scanning for Bone Density • Clinical Drug Trials

- **346 Mill Street, Hagerstown, MD 21740 Phone (301) 791-6680 Fax (301) 714-1506**
- **921 Seton Drive, Suites C&D, Cumberland, MD 21502 Phone (301) 724-4337 Fax (301) 724-3276**

AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider subject to the federal privacy regulations, the released information may no longer be protected by federal privacy regulations and that it may be re-disclosed by the recipient without my knowledge or permission.

**If this authorization is for marketing purposes, remuneration is / is not involved (Provider circle one).

Please release medical records of _____ Date of birth _____

FROM / TO (circle one) Klein & Associates, MD, PA

TO / FROM:_____

_____
Street City State Zip Code

Specific description of information to be disclosed (The following information *cannot* be disclosed without specific authorization: *psychotherapy notes, information regarding HIV, mental health, alcohol or drug abuse):*

Information to be released: _____

Purpose of disclosure: _____

Dates of the records that you are requesting: _____ (DD/MM/YY)

You must read and initial the following statements:

- I am entitled to a copy of this authorization. Initials: _____
- I understand this authorization will expire *one year* from date of signature. Initials: _____
- I understand that I may revoke this authorization by notifying Klein & Associates in writing, but if I do, it will not have any effect on any actions Klein & Associates took before they received the revocation. Initials: _____

_____ _____ _____
Signature of patient or Representative Relationship to patient Date

You may refuse to sign this authorization.
We cannot condition treatment, payment or other benefits on your signing this authorization.