

RHEUMATOLOGY ASSOCIATES

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The physicians of Rheumatology Associates often offer their patients an opportunity to participate in clinical research studies at Metroplex Clinical Research Center (MCRC). MCRC was established by Rheumatology Associates in 1984 to provide patients access to new treatments for rheumatologic diseases. If you choose to participate in a research study, you will be seen by a Rheumatology Associates physician or nurse practitioner for your study visits. Should your physician identify you as a potential study candidate, MCRC may contact you directly.

By signing this authorization, I authorize **Rheumatology Associates** to use and/or disclose certain protected health information (PHI) about me to **Metroplex Clinical Research Center**. This authorization permits **Rheumatology Associates** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc): name, address, telephone number, date of birth, and diagnosis, (collectively referred to as PHI).

The information will be used or disclosed for the following purpose:

My possible participation in a research study. If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization for release of information will cover all past, present and future periods.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Rheumatology Associates**. I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization, in writing, at any time. To revoke this Authorization, you must write to: Rheumatology Associates 8144 Walnut Hill Lane, Suite 800 Dallas, Texas 75231.

I hereby **GIVE** or **DENY** approval for Rheumatology Associates to share my PHI with MCRC.

Signed by: _____

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Relationship to Patient

Date

Print Patient Name

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION