OSR

Ocean State Rheumatology LLC

I understand and agree that my medical record will be maintained in a paper or electronic medical record (EMR) format and that records may be transmitted electronically via fax, e-mail, internet, or data transfer system.

I understand that Ocean State Rheumatology LLC cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or Ocean State Rheumatology LLC's Privacy Officer.

TO:

(This section will be filled out in case your records need to be sent to another physician. Please only sign and date)

Physician Name: _____

Address: _____

Phone: _____ **Fax:** _____

Signature of Patient _____ **Date** _____

_____

(Relationship or status if signed by anyone other that patient, parent or legal guardian, personal representative, etc.)

Address: 1030 President Avenue Suite 305A
Fall River, MA, 02720
Tel: 508.235.6744 Fax: 1.888.815.1696
Email: oceanstate.rheumatology@outlook.com