Arthritis Associates of Redding

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print

Patient Name | Other Last Names

Date of birth | Phone Number | Email Address

Street Address | City, State, Zip code

Transfer of care is required due to the closing of my physician's office. Therefore, I hereby authorize

Morgan Records Management LLC, 8 State Street, Nashua, NH 03063,

On behalf of**, Arthritis Associates of Redding, California** to execute one of the following:

Please select one of the following delivery options:

☐ Secure HIPAA approved electronic transfer **$25**: ***List email you want chart sent to here*:**

_____

☐ Disc mailed **$25** plus an additional **$10 shipping charge prior to mailing**. We mail USPS Certified Return Receipt. ***List address you want disc mailed to here:***

_____

I, _____, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my medical records. This form gives you permission to share my private information obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.

- **TO PAY BY CREDIT CARD** – please use our online form: MorganRecordsManagement.com-> Patient Records Requests -> Request My Medical Records
- **CHECK** - please mail your completed authorization form with an attached check or money order made payable to Morgan Records Management LLC, to 8 State Street, Nashua, NH 03063.

Patient or Legal Guardian Signature | Date

Patients over the age of 18 must sign. If a patient is unable to sign that is over the age of 18, legal documentation must accompany this release form.

Your completed authorization form may be emailed to Medical@MorganRM.com, or mailed to Morgan Records Management LLC, 8 State Street, Nashua, NH 03063.