ARTHRITIS CONSULTANTS OF TIDEWATER

RHEUMATOLOGY · OSTEOPOROSIS · INTERNAL MEDICINE
PHONE (757) 491-7359 · FAX (757) 491-9359

GARY R. SIEGEL, M.D., F.A.C.R.
MICHAEL R. CANNON, M.D.
JANICE SHERWOOD, M.D., F.A.C.R.
TATIANA KECK, M.D.
FREDILYNN LANSANGAN, NP-C

PLEASE PROVIDE INFORMATION FOR PCP, PRIOR RHEUMATOLOGIST, OR ANY OTHER PROVIDER THAT MAY HAVE SEEN YOU FOR YOUR CURRENT CONDITION/SYMPTOMS.

Authorization to Release/Receive/Exhange Confidential Medical Information

I hereby authorize **Arthritis Consultants of Tidewater** to **RELEASE/RECEIVE/EXCHANGE (circle one)** my medical record including HIV/AIDS, psychiatric, drug abuse, and alcohol related information, if applicable **TO/FROM/WITH (circle one):**

	Provider/Facility Name	Phone Number	Fax Number	Type of Practice
1				
2				
3				
4				
5				

Specific type of information to be disclosed:

- ☐ All Medical Records
- ☐ Most recent imaging studies.
- ☐ Hospital Admission/Discharge Summary
- ☐ Other: _____
- ☐ Most recent visit notes & labs
- ☐ Medications
- ☐ Physical

Purpose or need for such disclosure:

- ☐ Continuity of Care
- ☐ Other: _____
- ☐ Discharge and/or follow up planning

In understand that I have the right to revoke this authorization at any time by giving written notice however, I understand that any information released prior to my revoking this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke the authorization prior to such time, this authorization will expire 365 days from this date unless otherwise specified _____.

Last name (printed) First Middle Date

Birthdate Patient Signature (Guardian) Witness

933 First Colonial Road, Suite 100, Virginia Beach, VA 23454