ARTHRITIS CONSULTANTS OF TIDEWATER

RHEUMATOLOGY · OSTEOPOROSIS & INFUSION CENTERS
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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/Exchange 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 visit notes & labs
- ☐ Most recent imaging studies.
- ☐ Medications
- ☐ Hospital Admission/Discharge Summary
- ☐ Physical
- ☐ Other: _____

Purpose or need for such disclosure:

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

I 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

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