Arthritis Specialty Center **Ananda Walaliyadda, MD, FACR, CCD**

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

Patient's Name: _____Date of Birth:_____* LAST 4 SSN _____

Address: _____ City/State/Zip _____

Date of Request: _____ **Date Needed:** _____

☐ I authorize Arthritis Specialty Center to **release information to:**

Name of Provider/Patient

Address City/State/Zip

Phone/Fax# (include area code)

OR

☐ I authorize Arthritis Specialty Center to **obtain information from:**

Name of Provider

Address City/State/Zip

Phone/Fax# (include area code)

***PURPOSE FOR THIS REQUEST:** (Check one)

☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Transfer of Care ☐ Other: _____

***TYPE OF RECORDS REQUESTED:** (Check one)

☐ Treatment Summary (includes office visit notes, history & physical exam, x-ray results, & lab test results)
☐ Copy of entire medical record, as allowed by law.
☐ Specific information (Select one or more, as applicable)
☐ X-ray ☐ Labs ☐ Insurance Information ☐ Other: _____

☐ All medical records related to a specific illness or injury

Specify illness/injury Date(s) of treatment

***AUTHORIZATION VALID FOR: (**Check one.)

☐ This Request only
☐ One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until _____ (insert date).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- **The first copy of your records will be provided free of charge. A charge will be applied for each additional copy.**

Signature of patient or representative: _____ Date: _____

Relationship to patient: _____

1448 East Center Street, Ste E
Pocatello, ID 83201
Tel (208) 234-1300
Fax (208) 234-1333

711 Rigby Lake Drive, Ste 114
Rigby, ID 83442
Tel (208) 234-1300
Fax (208) 234-1333

Patient Initials_____ Received Date _____ Office Completed Date _____