



AUTHORIZATION TO RELEASE MEDICAL RECORDS & DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Patient's Address: _____ Telephone Number: _____

I AUTHORIZE THE RELEASE OF INFORMATION IN MY HEALTH CARE RECORD:
From: Valley Arthritis Care, LLC To: Self

I will pick up records when ready at MAIN SCW Please mail records to Patient's Address listed above.

INFORMATION TO RELEASE

- o Patient records of the past three years of treatment.
o All medical records (I understand this requires approval from the privacy officer and may take up to 30days)
o Medical Records from: _____ TO _____
o Specific records: (from the past year) Billing Office Notes Labs X-Ray Bone Density
o Other: (please explain and provide dates: _____)

Purpose: Patient Request Continue Medical Care Attorney Request Other

I understand that my health records may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency; (AIDS), Human Immunodeficiency Virus (HIV), Hepatitis C, and other communicable disease, Behavioral Health Care, Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes the release of such information. I may refuse to sign this authorization and understand that Valley Arthritis Care will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time in writing except to the extent that actions has taken based on this authorization, unless otherwise revoked this authorization is calid for one year.

I understand that once my information is released, Valley Arthritis Care will no longer be able to protect that information. I release Valley Arthritis Care and its employees from any legal liability that may arise from the disclosure of the above information.

I understand there is an administrative fee associated with to duplication of my records. Please allow 7-10 days for any duplication of records. For the release of all medical records please allow 30days.

Patient/Legally Authorized Representative Signature: _____ Date: _____

Dr. Ravi Bhalla, MD, FACR • Brady Nelson, PA • Iain Black, PA • Christina Foster, PA