Catalina Pointe Arthritis & Rheumatology Specialists, P.C.
Authorization to Release Medical Information

Patient Name: _____ **Date of Birth:** _____

I AUTHORIZE:

_____

_____

_____

TO RELEASE TO:

Catalina Pointe
Fax: 520-408-2233 Phone: 520-408-1133
7520 N. Oracle Rd, Ste 100
Tucson, AZ 85704

INFORMATION TO BE RELEASED: RECORDS FROM THE PERIOD: _____/_____/_____ to _____/_____/_____

☐ All Records ☐ All Progress/Consult Notes ☐ Lab Reports ☐ Radiographic Reports

☐ DXA Bone density reports ☐ Most recent Lab Report only ☐ Most recent Progress Note only

☐ Other: _____

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By initialing below, you are authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV

Initials:

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim

☐ Other: _____

I understand that this authorization shall be valid until the information is released. I understand that I may revoke this consent at any time except to the extent that action has already been taken. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. Catalina Pointe Arthritis & Rheumatology Specialists, PC, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information.

Patient/representative's Signature: _____ **Date:** _____