Puget Sound Rheumatology

20700 Bond Rd NE, Building B, Suite 104
Poulsbo, WA 98370
Tel: 360.930.6314 | Fax: 360.626.1292
Email: PSR@psrheum.com
Web: www.psrheum.com

AUTHORIZATION TO RELEASE RHEUMATOLOGY RECORDS TO PUGET SOUND RHEUMATOLOGY

Patient Name _____ DOB _____ Previous Name _____

Current Address _____ City _____ State _____ Zip _____

Primary Phone _____ Cell Phone _____

I authorize information to be sent FROM: _____

Address: _____ City, State, Zip: _____

I authorize information to be sent TO: Puget Sound Rheumatology

Address: 20700 Bond Rd. NE, Suite 104 City, State, Zip: Poulsbo, WA 98370

TYPE OF INFORMATION TO BE RELEASED

- [X] **Original** Rheumatology Consultation Note *and* **First Return** Consultation Chart Note
- [X] Chart Notes – **Last One (1) Year** _____ ☐ Other Date (s): _____
- [X] Rheumatology Medications – **Complete** _____ ☐ Other Date (s): _____
- [X] Lab, Pathology, etc. – **Last One (1) Year + Initial Consultation Labs** _____ ☐ Other Date (s): _____
- [X] X-ray/Diagnostic Imaging Reports – **Last Two (2) Years** _____ ☐ Other Date (s): _____
- [X] DXA Reports & Images – **Complete** _____ ☐ Other Date (s): _____
- [X] Infusion Records – **Complete** _____ ☐ Other Date (s): _____
- [X] Immunizations/TB Skin Test – **Last Two (2) Years** _____ ☐ Other Date (s): _____
- [ ] Other / Date (s) _____

THE INFORMATION SHOULD BE SENT BY THE FOLLOWING MEANS

- [X] **Please FAX immediately:** last chart note + most current lab/diagnostic results to 360.626.1292 for continuity of patient care.
- [X] **MAIL copies of ALL records** to Puget Sound Rheumatology at the above address.

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. By initialing below I authorize the release of the following protected or sensitive information.

_____ AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH-RISK BEHAVIOR
INITIAL

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

Signature of Patient or Legally Responsible Person _____ Relationship to Patient _____ Date _____