Board Certified in Rheumatology and Internal Medicine
3560 Delaware, Suite 301
Beaumont, Texas 77706
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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

Patient Name : ____
Print patient name

Previous Name : ____

Social Security Number : _____/_____/______ Date of Birth : _____/_____/______

I hereby, authorize _______________________________ to release healthcare information of the patient name above to :

Dr. Reeti Joshi, M.D
3560 Delaware, Suite 301
Beaumont, Texas 77706

This request and authorization applies to :

- o All healthcare information
- o Health information related to the treatment, condition, or dates ____
- o Other Labs & X-rays only, radiology

I understand that, with the exception of actions already taken, this authorization may be voided by me at anytime. This authorization may be revoked by written communication to the Medical Records Department.

THIS AUTHORIZATION IS VAILD FOR 12 MONTHS AFTER THE DATE SIGNED BY THE PATIENT OR LEGAL REPRESENTATIVE.

____ Date : ______________________
Patient Signature [or parent, guardian or legal representative]

____ Date : ______________________
Advanced Rheumatology Associates Employee Signature