



**ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY**

1725 Birmingham Rd., Ste. 200, College Station, TX 77845 · (979) 696-8000 · (979) 696-8100 fax

**Board Certified in Rheumatology**

**Ricardo Pocurull, MD, FACR    Rajpreet Singh, DO, FACR**

**Laura Smith, PA-C**

**Release of Medical Information**

Name of Patient	
Date of Birth	

**Records released from:**

Physician/Facility Name			
Address			
Phone		Fax	

**Record released to:**

Physician/Facility Name	Ricardo Pocurull MD, Rajpreet Singh DO, Arthritis & Osteoporosis Clinic (AOC)		
Address	1725 Birmingham Rd. Ste. 200		
City, State Zip	College Station, TX 77845		
Phone	(979)696-8000	Fax	(979)696-8100

**Records to be released:**

<input type="checkbox"/> Lab Report	<input type="checkbox"/> Imaging report	<input type="checkbox"/> Clinical Notes	<input type="checkbox"/> Entire history	<input type="checkbox"/> Other:
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**Record time period:**

<input type="checkbox"/> Most Recent	<input type="checkbox"/> 3- 6 months	<input type="checkbox"/> Entire history	___/___/___ to ___/___/___
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**Purpose:** The purpose of this authorization to release medical information is for continuity of care at the request of the individual.

**Right to revoke:** I have the right to withdraw my consent at any time with written notice. Prior actions in reliance on this authorization will not be affected. \*Please see privacy practice on instructions how to revoke\*

**Signature for authorization:** I understand that information disclosed may be subject to re-disclosure and may no longer be protected by federal or state privacy laws. Refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without specific authorization or permission, including disclosures to covered entities as provided by the Texas Health & Safety Code § 181.154(c) C.F.R. § 164.502(a)(1).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Legally Authorized Representative

Printed name of legal representative: \_\_\_\_\_

Description of legal representative's authority to act for the individual: \_\_\_\_\_

**This authorization will expire 90 days from date of signature.**

Confidentiality Notice

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08/27/2024