Naga S. Bushan, M.D. | J. Michael Calmes, M.D. | José Del Giudice, M.D.
Taylor Warmoth, M.D. | Autumn Beasley, F.N.P.

July 13, 2022

Dear Patient:

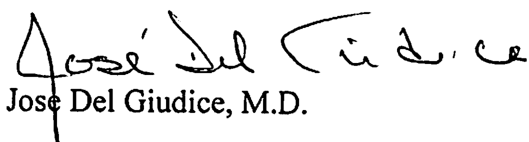
I am writing to inform you of my retirement from Arthritis & Osteoporosis Associates, effective October 13, 2022. Caring for you, my patient, has been the most rewarding part of my 24-year career in Lubbock, Texas. I have come to know many of my patients and their families as friends and I am honored that many of you have asked me to care for close family members.

As I transition toward retirement, I recommend you continue under the care of one of our caring providers at Arthritis & Osteoporosis Associates (AOA). AOA has three Board Certified Rheumatologists (Naga Bushan M.D., J. Michael Calmes M.D., and Taylor Warmoth M.D.), three mid-levels (Autumn Beasley FNP, Lynsey Blankenship FNP and Ravyn Barr FNP) and of course our wonderful support staff. As my retirement date nears, we will work with you so that you may make a smooth transition to one of our other providers. At your next appointment, we will discuss this transition.

Regarding your confidential medical records, if you choose to remain with one of AOA's providers, you do **not** need to take any action concerning your medical records. If you should decide to transfer your care to another Rheumatologist outside of AOA, my office staff will be available to help you obtain copies of your medical records once written consent is received as well as transfer to your new physician if needed. (See attached form-- Note: by law we cannot share your medical information without your written consent.)

I am sorry that I cannot continue as your physician. Please accept my warmest thanks for your patronage and friendship over the years. As we all move forward, I wish only the best for you and your family.

Sincerely,



José Del Giudice, M.D.

Included: medical records release form

5220 80th Street • Lubbock, TX 79424 • Phone (806) 771-2400 • Fax (806) 771-7760

Arthritis & Osteoporosis Associates LLP
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: ______________________________
Other Name(s) Used: ______________________ Date of Birth: ______________
Address: ______________________ City: __________ State: _____ ZIP: _________
Phone: (____) ____________________ Email (*Optional*): ______________________

Information regarding health care provider or health care entity authorized to disclose this information:
Name: Arthritis & Osteoporosis Associates LLP
Address: 5220 80th St. Lubbock, TX 79424
Phone: 806-771-2400 Fax: 806-771-7760

Information regarding person or entity who can receive and use this information:
Name: ______________________________
Address: ______________________ City: __________ State: _______ ZIP: _________
Phone: (____) ____________________ Fax: (____) ______________________

Specific information to be disclosed:
□ Medical Record from (insert date) ______________ to (insert date) ______________
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: ______________________________

Include: (*Indicate by Initialing*)	Reason for release of information: *(Choose all that Apply)*
________ Drug, Alcohol or Substance Abuse Records	□ Treatment/Continuing Medical Care
________ Mental Health Records (Except Psychotherapy Notes)	□ Personal Use
________ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)	□ Billing or Claims
________ Genetic Information (Including Genetic Test Results)	□ Insurance
	□ Legal Purposes
	□ Disability Determination
	□ School
	□ Employment
	□ Other *(Specify)*: ______________

<u>The individual signing this form agrees and acknowledges as follows</u>:

1. **<u>Voluntary Authorization</u>:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

2. **<u>Effective Time Period</u>:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: ________ Day: ________ Year: _________.

3. **<u>Right to Revoke</u>:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. **<u>Special Information</u>:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

5. **<u>Signature Authorization</u>:** I have read this form and agree to the uses and disclosure of the information as described. I understand that 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 my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: ____________________________________ Date: _____________

If Legal Representative, relationship to Patient: ______________________________________

Witness (optional): ____ Date: _____________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): ________________________________ Date: _____________