

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

BOARD CERTIFIED RHEUMATOLOGISTS

HERBERT S.B. BARAF, MD FACP FACR
ROBERT L. ROSENBERG, MD FACR
EVAN L. SIEGEL, MD FACR
EMMA DIORIO, MD FACR
ALAN K. MATSUMOTO, MD FACR

DAVID G. BORENSTEIN, MD FACP FACR
ROBERT J. LLOYD, MD MACR
DAVID P. WOLFE, MD FACR
PAUL J. DEMARCO, MD FACP FACR
SHARI B. DIAMOND, MD, FACR

ASHLEY D. BEALL, MD FACR
ANGUS B. WORTHING, MD FACR
GUADA R. RESPICIO, MD FACR
JUSTIN PENG, MD

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: ____ / ____ / ____
 Address: _____ City: _____
 State: _____ Zip Code: _____ Phone #: _____

I authorize Arthritis & Rheumatism Associates, P.C. to **use/disclose the following information to:**

Myself See additional designee(s) attached

Name of Provider / Facility / Person(s)

Address

City / State / Zip Code

(____) - ____ - ____ (____) - ____ - ____
Phone Number Fax Number

I authorize Arthritis & Rheumatism Associates, P.C. to **receive the following information from:**

Name of Provider / Facility / Person(s)

Address

City / State / Zip Code

(____) - ____ - ____ (____) - ____ - ____
Phone Number Fax Number

RECORDS TO BE RELEASED:

Progress Notes:	<input type="checkbox"/> Most Recent	<input type="checkbox"/> From _____	to _____	<input type="checkbox"/> All
Labs:	<input type="checkbox"/> Most Recent	<input type="checkbox"/> From _____	to _____	<input type="checkbox"/> All
Radiology:	<input type="checkbox"/> Most Recent	<input type="checkbox"/> From _____	to _____	<input type="checkbox"/> All
DEXA:	<input type="checkbox"/> Most Recent	<input type="checkbox"/> From _____	to _____	<input type="checkbox"/> All
EMG:	<input type="checkbox"/> Most Recent	<input type="checkbox"/> From _____	to _____	<input type="checkbox"/> All
Physical Therapy:	<input type="checkbox"/> Most Recent	<input type="checkbox"/> From _____	to _____	<input type="checkbox"/> All
Other:	_____			

PURPOSE(S) FOR THIS REQUEST:

Referred to Outside Provider Changing Physicians Physician's Request Personal Use
 Insurance Purposes Legal Purposes Moving Employer's Request
 Other: _____

Initials I understand that the person(s) (or practice) I am authorizing to use/disclose my protected health information may charge a third party for doing so.

Initials I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment, payment, or eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. If I refuse to sign this form, the practice cannot use or disclose my protected health information for purposes outside TPO. (Treatment, Payment, and healthcare Operations)

Initials I understand that if the party receiving this information is not a healthcare provider or health plan subject to the federal privacy regulations that the information described above may be re-disclosed and no longer protected by the privacy regulations.

Initials I understand that I may revoke this authorization in writing at any time except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at 2730 University Boulevard West, Suite 310, Wheaton, MD 20902.

This authorization becomes effective _____ and will expire _____. (Authorization may not exceed one year)

Signature of Patient or Personal Representative Date

Print Patient Name or Personal Representative Name Relationship to Patient

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MEDICAL RECORDS RELEASE FORM –ADDITIONAL DESIGNEE(S)

<input type="checkbox"/> I authorize Arthritis & Rheumatism Associates, P.C. to use/disclose the following information to: _____ Name of Provider / Facility / Person(s) _____ Address _____ City / State / Zip Code (____) - ____ - ____ (____) - ____ - ____ Phone Number Fax Number	<input type="checkbox"/> I authorize Arthritis & Rheumatism Associates, P.C. to use/disclose the following information to: _____ Name of Provider / Facility / Person(s) _____ Address _____ City / State / Zip Code (____) - ____ - ____ (____) - ____ - ____ Phone Number Fax Number				
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<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> _____ Signature of Patient or Personal Representative </td> <td style="width: 50%; border: none;"> _____ Date </td> </tr> <tr> <td style="border: none;"> _____ Print Patient Name or Personal Representative Name </td> <td style="border: none;"> _____ Relationship to Patient </td> </tr> </table>		_____ Signature of Patient or Personal Representative	_____ Date	_____ Print Patient Name or Personal Representative Name	_____ Relationship to Patient
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