

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

**PATIENT AUTHORIZATION
Use and Disclosure of Protected Health Information**

Patient's Name: _____ Social Security # _____

1. Persons or group of persons authorized to **use/disclose** this information

Name _____

Address _____

2. Persons or group of persons authorized to **receive** this information

Name _____

Address _____

3. Description of the information to be used or disclosed:

4. Purpose for Disclosure of Information:

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

Patient Initials

6. 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. _____

Patient Initials

7. I understand that if the party receiving this information is not a health care 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. _____

Patient Initials

8. 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.

9. This authorization becomes effective _____ and will expire _____.
(Authorization may not be longer than one year)

Signature of Patient or
Personal Representative

Date

Print Patient Name or Personal Representative Name

Relationship to Patient