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 DiIORIO, 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:	☐ Most Recent	☐ From	_____ to _____	☐ All
Labs:	☐ Most Recent	☐ From	_____ to _____	☐ All
Radiology:	☐ Most Recent	☐ From	_____ to _____	☐ All
DEXA:	☐ Most Recent	☐ From	_____ to _____	☐ All
EMG:	☐ Most Recent	☐ From	_____ to _____	☐ All
Physical Therapy:	☐ Most Recent	☐ From	_____ to _____	☐ 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

2730 University Boulevard West. Suite 310. Wheaton, Maryland 20902. FAX 301.942.3132
14955 Shady Grove Road. Suite 230. Rockville, Maryland 20850. FAX 301.251.5913
2021 K Street, N.W. Suite 300. Washington, DC 20006. FAX 202.293.9416
5454 Wisconsin Avenue. Suite 600. Chevy Chase, Maryland 20815. FAX 240.497.0233
CENTRAL CALL CENTER 301.942.7600 • **www.washingtonarthritis.com**

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MEDICAL RECORDS RELEASE FORM –ADDITIONAL DESIGNEE(S)

☐ 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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