ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

2730 University Blvd. West, Ste 310, Wheaton, MD 20902 14995
Shady Grove Road, Ste 250, Rockville, MD 20850
5454 Wisconsin Avenue, Ste 600, Chevy Chase, MD 20815
18111 Prince Philip Drive, Ste 323, Olney, MD 20832
71 Thomas Johnson Drive, Frederick MD 21702
2021 K Street, NW, Ste 300, Washington, D.C. 20006
3027 Javier Road, Ste 2, Fairfax, VA 22031

MEDICAL RECORDS RELEASE FORM

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

☐ I authorize Arthritis & Rheumatism Associates, P.C. (ARAPC) 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. (ARAPC) 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:

☐ **ARAPC Records ONLY** ☐ **Include Records from Outside Providers**

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.

By signing this authorization it becomes effective immediately and will expire once the request has been completed. Every new request thereafter will require a new authorization form to be completed, per our practice policy.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Patient Name or Personal Representative Name Relationship to Patient