

**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
 8270 Willow Oaks Corporate Drive, Ste 150, Fairfax, VA 22031

MEDICAL RECORDS RELEASE FORM

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

<input type="checkbox"/> I authorize Arthritis & Rheumatism Associates, P.C. (ARAPC) to use/disclose the following information to: <input type="checkbox"/> Myself <input type="checkbox"/> See additional designee(s) attached 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. (ARAPC) to receive the following information from: Name of Provider / Facility / Person(s) _____ Address _____ City / State / Zip Code _____ (____) - ____ - ____ (____) - ____ - ____ Phone Number Fax Number
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RECORDS TO BE RELEASED:

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

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:

____ 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.
 Initials _____

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 _____