

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
161 Thomas Johnson Drive, Ste 250, 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 #: _____

☐ 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
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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