PATIENT MEDICAL RECORDS REQUEST

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name**:** _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information:(records are coming from)

Rheumatology and Arthritis Care Center
766 W. Lincoln Hwy, Exton PA 19341
(p) 484-206-4447
(f) 484-237-9565

B. Person(s) or Organization(s) authorized to receive the information: (records are going to)

Name_____

Address_____

Phone/Fax_____

Please indicate Delivery Preference: [ ] USPS Mail [ ] Fax [ ] Pick Up

C. Specific description of the information that may be used or disclosed (including date(s)): Notes, Labs and Imaging

D. Specific description of how the information will be used: Continued Medical Treatment

1) I understand that any copy of medical records when the patient is the recipient are subject to Pennsylvania based medical record fees.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in **A** (above) in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable.
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would **no longer be protected** by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

You have the right to know specifically what information you are authorizing for release

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information.

You have the right to know who is going to use it and what it is going to be used for.

You have the right to alter this request. We have preprinted options for your convenience. You may alter these items if needed.

You have the right to receive a copy of this form