Advanced Rheumatology & Arthritis Research Center, PC

10431 Perry Highway
Suite 300
Wexford, PA 15090

Telephone: (724)-935-9355
Fax: (724)-935-9360

Authorization for Release of Protected Health Information

Patient Name: _____
Last First Initial

Address: _____

DOB: _____ Social Security Number: _____

I have been a patient at the Physician Practice or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I, _____hereby authorize _____

to release my protected health information to _____

The following information or copies of: **(place a check by types of records desired)**

__ Allergy list
__ Hospital documents (H&P, op notes, discharge summary, etc.)
__ Lab Results
__ Radiology Results (Xray, CT, MRI, etc)
__ Immunization Records
__ Medication list
__ Problem list
__ The above information and/or the entire Medical Record which includes HIV-related information.
__ The above information and/or the entire Medical Record including mental health, drug or alcohol treatment.
__ Entire Medical Record **EXCLUDING** HIV-related, mental health, drug or alcohol treatment
__ Billing or other business records **(specify)** : _____
__ Other (specify): _____
From (date): _____to (date): _____

Reason for Request:
__ Continuing treatment __ Insurance __ Legal __ Employer __ Study/Research __ Second Opinion
__ Other _____ __ **I do not wish to disclose the reason**

This authorization will expire in six months or _____
(specify expiration date, event or time frame for expiration)

I understand that this authorization is subject to revocation at any time, except to the extent that Advanced Rheumatology and Arthritis Wellness Center, PC, or the above named individual, Facility, Agency, School or Entity has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive.

_____ _____
Patient or Representative Signature Date Witness Date
(If representative, give relationship and authority to act) *(when required by policy or signing by mark)*