

RECORDS REQUEST

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

Patient Name: _____

Patient's Date of Birth: _____

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

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

**TRI COUNTY RHEUMATOLOGY
1650 HUNTINGDON PK, STE 352, MEADOWBROOK PA 19046
PH: 267-571-2151 FAX: 215-379-8387**

C. Specific description of the information that may be used or disclosed (including dates):

D. Specific description of how the information will be used: CONTINUED MEDICAL TREATMENT

- 1) I understand that this authorization will **expire** on _____.
- 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 re-disclosed 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 (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).

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