Arthritis and Rheumatology Consultants, P.A.

# AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

**PATIENT INFORMATION**

Patient name | Date of Birth

Street Address | Email Address

City | State | Zip Code | Phone Number

**RELEASE MY RECORDS FROM**

****check one option**

☐ Arthritis & Rheumatology Consultants, P.A.
Phone# 952-893-1959 Fax# 952-893-1954

**OR**

☐ External/Outside Facility (complete only if requesting outside records)

Street Address | Phone Number

City | State | Zip Code | Fax Number

**SEND MY RECORDS TO**

Person/Business/Hospital/Clinic | Phone Number | Fax Number

Street Address | City | State | Zip Code

**PURPOSE FOR RELEASE**

☐ Continuing Care ☐ Personal Use/Review * ☐ Litigation/Legal * ☐ Insurance Application * ☐ Insurance Payment/Claim
☐ Social Security Disability * ☐ Social Security Appeal ☐ Disability Insurance ☐ Other * _____

**Fees may be charged in accordance with MN Statute 144.2923 and Federal Rule 45 C.F.R. §164.524*

**INFORMATION TO BE RELEASED:**

**I want my records related to:** _____

**I want my records for dates of service:** _____

☐ Radiology Images* (**Will be sent separately)*

**What Information do you want disclosed?**

☐ Clinic Record Set (office visit notes, lab, radiology report, med list, immunizations)

☐ Hospital Record Set (history & physical, discharge summary, operative report, consultations, emergency records, lab, radiology report)

Individual Report Options:

| | | | |
|---|---|---|---|
| ☐ Discharge Summary/Note | ☐ Clinic/Progress Notes | ☐ Laboratory Reports | ☐ Immunization Record |
| ☐ History & Physical Exam | ☐ Emergency/Urgent Care | ☐ Pathology Reports | ☐ Allergy Record |
| ☐ Operative Report | ☐ Rehab Notes (PT/OT/ST/RT) | ☐ Radiology Reports | ☐ Medication Records |
| ☐ Consultations | ☐ Home Health/Hospice | ☐ EKG/ECHO | |

☐ **All Medical Records** ☐ Other Records (specify type): _____

**Special Disclosure Permissions**

☐ Chemical Dependency/Substance Use Program Records ☐ Genetic Counseling Records

**Wisconsin Records Only:** ☐ Mental Health Records ☐ HIV Test Results

**RELEASE METHOD/FORMAT**

▶ **Date Records are Needed (appointment date):** ____/____/____ **(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)**

☐ Pick up in person ☐ U.S. Mail

☐ Fax (Patient Care Only-See Above) ☐ Patient Portal

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____/_____/_____
  *This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.*
- Arthritis and Rheumatology Consultants, P.A. will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Arthritis and Rheumatology Consultants, P.A. records may include records that it received from other organizations. If these records have been used by Arthritis and Rheumatology Consultants, P.A. and filed in the record we maintain about you, these records may be released with your Arthritis and Rheumatology Consultants, P.A. records.
- Arthritis and Rheumatology Consultants, P.A. cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Arthritis and Rheumatology Consultants, P.A. from any and all liability resulting from a redisclosure by the recipient.
- Federal Rule 42 CFR part 2 prohibits unauthorized disclosure of Substance Use Program Records
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Patient/Legal Guardian Signature _____ Date _____ Authority to act on behalf of patient (attach document) _____

## Directions for Completion of Form

**Patient Information:** Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual about whom information is being requested)

**Release My Medical Records From**: Check the first box if you would like your records released from an Arthritis and Rheumatology Consultants, P.A. (ARC) facility/provider. Check the second box if you are requesting your records be released from a **non**-ARC facility/provider.

**Send My Medical Records To**: Identify the full name/business, address, phone and contact information with the name of the individual who is to receive the information. *Please allow 7-10 days for all requests to be processed and sent to the recipient*.

**Purpose For Release**: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

**Information to Be Released**: This section gives us the instructions for what information you want released. If you select "Clinic Record Set" or "Hospital Record Set", we will disclose the pertinent documents that are specific to that type of patient care visit. This is typically what doctors' offices, hospitals or other health care providers need to provide information related to your care. If you select "any and all" records, your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor. Please note record types listed in the Special Disclosure Permissions section must be checked in order for them to be released.

**Release Method**: This tells us how you would like your information delivered. If you wish information about you to be shared verbally or for an authorization to be on file for others to have access to your medical information, please write this in this section.

**Duration of the authorization, revocation and other information you need to know:** This authorization will automatically expire in 12 months **unless** you include a different date. You may indicate the authorization is valid "5 years", "10 years", but there needs to be an ending date (do **not** use terms such as "lifetime" or "forever"). The authorization can be revoked by your written direction to our organization.

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**Contact Information for Patient Record Copies**

Arthritis & Rheumatology Consultants, P.A.
7600 France Ave S, Suite 5100
Edina, MN 55435
Phone: 952-893-1959
Fax: 952-893-1954