**Rheumatic Disease Associates, Ltd.**
C. Michael Franklin, MD, FACP, FACR, RhMSUS
Charles Pritchard, MD, FACP, FACR, RhMSUS
Mark Lopatin, MD, FACP, FACR, FCPP
David J Chesner, DO, FACR, FACOI
Elana R. Eisner, MD, FACP, FACR, RhMSUS
Dennis A. Jerdan, MD, MBA, FACR
Marguerite L. McGarvey, MD, FACR

Sarah Coleman, MD, FACR
Dana Jacobs-Kosmin, MD, FACP, FACR
Monica Mohile, MD, FACR
Katherine McCambridge, PA-C
Shannon Lutz, PA-C
Wendy Grace, CRNP
Jamie Lobbenberg, CRNP

# Authorization For Release Of Protected Health Information

Patient's Name: ___________________________________ Date of Birth:___________________

Address: ________________________________________ Phone:_________________________

I, ________________________________________, authorize ________________________________________________
(Print Name) (HealthCare Provider/Other)

to release my personal health information to_____________________________________________________
(HealthCare Provider/Other)
Address: ________________________________________________________or Fax to:_______________________

Dates of information to be disclosed: From _____________ to__________. (*If left blank, only information from the past two years will be disclosed.*)
Description of information to be released, including dates, if applicable:
_____________________________________________________________________________________________

I do not want the following information disclosed (as defined by applicable state and federal laws):
__________ Alcohol/Drug Abuse; __________. HIV Test Results; _________Mental Health/Developmental Disabilities

Your rights with respect to this authorization: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization or needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage.

Signature of patient/legal representative: ____________________________________Date: ____/____/____

**If signed by a person other than the patient, complete the following:**
Individual is: ___ a minor; _____legally incompetent or incapacitated; _______deceased
Legal authority: _____parent; _____guardian; _____next of kin/executor of deceased; ___**activated** POA for health care.

*Specializing in Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Lupus, Lyme Disease*

Main Office:
**Willow Grove Office**
2360 Maryland Road
Willow Grove, Pa 19090
Phone: 215-657-6776
Fax: 267-913-5961

Other Offices:
**Jenkintown Office**
610 Old York Road, Suite 678
Jenkintown, Pa 19046
Phone: 215-657-6776
Fax: 215-947-4204

**Doylestown Office**
599 West State Street, Suite 310
Doylestown, Pa 18901
Phone: 267-893-6780
Fax: 267-893-6784

**Newtown Office**
One Summit Square, Suite 101
1717 Langhorne-Newtown Rd.
Langhorne, PA 19047
Phone: 215-657-6776
Fax: 267-913-5961