Rheumatology Care Associates
We Care

Medical Record Request Form

Requesting information on the following patient:
Patient Name: _____ DOB: _____

REQUESTING PHYSICIAN: Dr. Priya Prakash

AUTHORIZING RECORDS TO BE RELEASED FROM:
Physician First & Last Name: _____
Address: _____
Phone Number: _____ Fax: _____

I hereby authorize the release of all medical records in your possession regarding my illness/ treatment as indicated to the requesting physician. I understand that the disclosed information may be subject to re-disclosure by the recipient. Please forward all records to:

Rheumatology Care Associates PLLC
RECORDS REQUESTED: Please send only the most recent unless otherwise specified.

- ____ Progress Notes
- ____ X-ray
- ____ MRI
- ____ EKG
- ____ Infusion Report
- ____ Labs
- ____ DEXA
- ____ CT scan
- ____ EMG/NCS

Purpose of Disclosure: __ Medical Care __ Insurance __ Attorney __Other (specify) _____

- **Patient Name (Print): ----------**
- **Patient Signature: ----------**
- **Date: -------/----------/----------**

(This authorization is valid for 180 days from signed date and may be revoked in writing at any time)

Rheumatology Care Associates PLCC. Address: 2741 Citrus Tower Blvd, Clermont, FL-34711
Phone :352-717-0603 Fax: 352-717-0604
Website:*www.rheumatologycareassociates.com*
***Email**: info@rheumatologycareassociates.com*