Rheumatology Care Associates
We Care

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ----------

DOB: ----------

I hereby give my consent to

Rheumatology Care Associates PLCC to release my medical records to:

Name/Facility ----------

Address----------

Phone----------

Fax: ----------

Information to be released: any and all reports of diagnoses, treatment, prognosis, and recommendations, as well as other data pertinent to treatment during the period:

From: ----------To: ----------

Patient or Guardian's Name (print): _____
Signature: _____
Date: _____

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