



RECORDS RELEASE REQUEST

To:

I, _____, hereby request that you release my MEDICAL RECORDS to:

Central Florida Rheumatology Consultants, LLC
915 Harley Strickland Blvd
Orange City, FL 32763 Phone: (386) 561-9967
Fax: (844) 815-1446

This includes a report of my diagnosis, treatment, prognosis and recommendations, as well as any other data pertinent to your treatment of me. I request ALL of my records to be sent unless specific dates or specific tests are listed below. Thank you.

- Release records only for the following period.

FROM: ____/____/____ TO: ____/____/____

- Release records only for the following test(s) / report(s): (Please Include Dates)

REASON FOR REQUEST:

___ Continuity of care treatment

___ At the Request of individual please include all sensitive information

Date of Request _____ Date of Birth _____

Social Security Number _____ Patient's Telephone Number _____

Patient Printed Name _____

I understand and give my permission for my records to be sent via facsimile (fax machine).

Patient Signature _____

Faxed: ____/____/____