Central Florida Rheumatology Consultants, LLC

Shikha Mehta, M.D,
ABIM board certified Adult Rheumatologist

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).

_____
Patients Signature Faxed:_____/_____/_____