
Records Release Request

To:

PCP: _____

Other: _____

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: ____/____/____ or Present

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

Labs _____ CT Scans: _____
 X-rays _____ Last Visit Note
 MRI _____ Other: _____

REASON FOR REQUEST:

Date of Request: _____

____ Continuity of Care/Treatment ____ At the Request of Individual please include all sensitive information

Patient Printed Name: _____ DOB: _____

Patient Phone Number: _____

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

Patient Signature: _____ Faxed: ____/____/____