



Phone number: 813-333-5080

Fax number: 813-773-7717

TAMPA

3102 W Cypress St

BRANDON

517 Eichenfeld Dr
Unit 102

SUN CITY CENTER

938 Cypress Village Blvd

LAKWOOD RANCH

6310 Health Park Way
Suite 130

VENICE

411 Commercial Ct- Ste C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE PUT YOUR PREVIOUS RHEUMATOLOGIST AND PCP NAME (IF APPLICABLE) SO THAT WE CAN GET PREVIOUS RECORDS WHICH WILL BE HELPFUL FOR YOUR CARE HERE.

Date of request : _____

To: _____ Fax: _____

Patient Name: _____ DOB: _____

Records Requested:

Please fax us patient's FIRST AND LAST OFFICE VISIT NOTE along with all pertinent labs , DEXA and imaging to 813 773 7717 (Fax number) 813 333 5080 (Phone number)

By my signature below, I hereby authorize the release of my medical records including all tests ordered, their results and examination notes from all providers to be released.

Patient Signature

Date

Confidentiality:

The information contained in this facsimile message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail or if electronic, reroute to sender. Thank you. If you do not receive all pages please contact the sender at above number.