Phone number: 813-333-5080 Fax number: 813-773-7717

TAMPA	BRANDON	SUN CITY CENTER	LAKEWOOD RANCH	VENICE
3102 W Cypress St	517 Eichenfeld Dr Unit 102	938 Cypress Village Blvd	6310 Health Park Way Suite 130	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