Rheumatology and Arthritis
Care Center

Authorization to Release/Transfer Medical Records

Date:______________________

To:____
Physicians Name

____
Address

____
City State Zip

I hereby authorize the above to release any and all medical records, including but not limited to hospitalization for diagnosis and or treatment of psychiatric and or mental condition, alcoholism, drug abuse and/or HIV test results, AIDS or related conditions.

Release to:____
Physicians Name

____
Address

____
City State Zip

____________________________________ ______________________________
phone fax

Uses

The purpose of the release of this information is for Continuity of Medical Care

Patient Information (Please Print)

Patient Name____

Address____

City, State, Zip____

SS #_______________________________________

Patient signature:____________________________________ **Date**:________________