ARTHRITIS & RHEUMATOLOGY
CENTER OF SOUTH FLORIDA

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Medical Records Release

Date:_____

To:_____

Phone:_____ Fax: _____

I hereby request that my medical records be released to:

Arthritis & Rheumatology Center of South Florida

_____

The complete medical records in your possession concerning my illness and/or treatment during the period from

_____ to _____.

Name _____ Date of birth _____

Signature _____

Thank you in advance