RELEASE OF MEDICAL RECORDS

Physician (s) or Facility with current records:

MD/Facility Name:_____

Address:_____

Phone:( ) _____

Fax: ( ) _____

Please release my medical records to the following physician(s) or facility:

Arthritis Clinic of NOVA, P.C
1635 N. George Mason Dr #220
Arlington, VA 22205
Phone (703)525-3069
Fax (703)525-3850
ArthClinic@gmail.com

Please send all information/records from my treatment with you or your facility. With my authorization I release you and/or your facility and the doctor(s) and or/facility receiving these records from legal responsibilities regarding my records realizing that my records may contain sensitive information.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____