ARTHRITIS & RHEUMATIC DISEASES, P.C.

329/331 McLaws Circle
Williamsburg, VA 23185
(P) 757-220-8579
(F) 757-345-0936

AUTHORIZATION TO RELEASE RECORDS

Patients Name: _____

Date of Birth: _____ SS#: _____

I hereby authorize release of my medical records to the person or persons listed below:

Arthritis & Rheumatic Diseases, P.C.
329 McLaws Circle
Williamsburg, VA 23185
(P) 757-220-8579
(F) 757-345-0936

I have given my consent freely, voluntarily, and without coercion. I may revoke the authorization at any time provided I notify the requesting physician in writing to that effect. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Term: I understand that this Authorization will remain in effect and will allow Arthritis & Rheumatic Diseases the ability to request medical records on my behalf for the following period of time: (Check One)

[ ] From the date of this Authorization until the _____ day of _____, 20____.
[ ] All past, present, and future time periods.

Patient Signature: _____ Date: _____