

Arizona Rheumatology Consultants

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RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

By signing below, I hereby release my medical records:

From:

To:

Dr./Facility's Name

Dr./Facility's Name

Phone Number

Phone Number

Fax Number

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Please send the following information:

Patient/Guardian Signature:
