1051 Pemberton Hill Rd, Suite 201, Apex, NC 27502
Ph: 919 727 6492
Fax: 916 581 8687

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ____

DOB: _________________________

I hereby give my consent to:

Practice Name: ____

to release my medical records to:

Name/Facility: **Arogya Rheumatology PLLC**

Address: **1051 Pemberton Hill Rd, Suite 201, Apex, NC 27502**

Phone: **919-727-6492** Fax: **916-581-8687**

Information to be released: any and all reports of diagnoses, treatment, prognosis, and recommendations, as well as other data pertinent to treatment during the period:

From: _____________________________ To: ____________________________________

Patient's Signature ___________________________________ Date ___________________