AROGYA
RHEUMATOLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____

DOB: _____

I hereby give my consent to:
Arogya Rheumatology PLLC

to release my medical records to:

Name/ Facility: _____

Address: _____

Phone: _____ Fax: _____

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 _____