

# ARTHRITIS & OSTEOPOROSIS CENTER, P.C.

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## RECORDS RELEASE/REQUEST

To \_\_\_\_\_  
(Doctor/Hospital)

Address \_\_\_\_\_  
(Number and Street)

\_\_\_\_\_  
(City) (State) (Zip Code)

I hereby authorize the release of my \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ or copies of such and  
request that they be transferred to the **Arthritis & Osteoporosis Center, P.C.**

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
Date of Birth

Date of Records \_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_/\_\_\_\_/\_\_\_\_  
(From) (To)

\_\_\_\_\_  
(Patient's Signature)      \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date)