



LOUDOUN
RHEUMATOLOGY
C E N T E R
Healthy Joints . Healthy Bones

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Date:

RECORDS REQUEST

Records coming from _____
(Doctor or Hospital)

(Address)

(phone)

(fax)

I hereby authorize the release of my complete medical records while under your care. I appreciate you forwarding my records to Dr Odutola's office at your earliest convenience. Thank you.

Name of Patient _____

Signature of Patient _____