LOUDOUN RHEUMATOLOGY CENTER
Healthy Joints . Healthy Bones

RELEASE OF MEDICAL RECORDS

Patients Name:			
Patients DOB:		Phone #:	

I hereby authorize *Loudoun Rheumatology Center* to release to:

Practice Name:			
Practice Address:			
City, State, Zip			
Phone #:		Fax #:	

◯ All of my Medical Records ◯ Consult Note

◯ Lab Work ◯ Imaging Studies

◯ Other _____

From Dates:		To Dates:	

Patients Signature:		Date:	

Records will be forwarded after receipt of payment. Please be advised that it takes up to 7-10 business days to process. Medical Records are processed through a third party.

If you have any questions, please do not hesitate to call our office.

Sincerely

Jennifer Odutola, MD
Gulrukh Saleem, MD
Caroline D'Souza, MD

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