



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

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Date: _____

RECORDS REQUEST

Records coming from _____
(Physician or Hospital)

(Address)

Phone: _____

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

Name of Patient: _____
(Please Print)

Signature of Patient: _____