



Release of Medical Records Authorization

Today's date: _____

To _____

Patient Name: _____

Date of Birth: _____

Dear Doctor:

The above named patient is currently under our care. Please forward pertinent medical records including laboratory and x-ray reports to:

Pacific Arthritis Care Center
Attn: Medical Records
5230 Pacific Concourse Drive, Suite 100
Los Angeles, CA 90045

or fax to (310) 297-9222

Thank you.

Patient signature of authorization:

Name:
