FAMILY ARTHRITIS CENTER

☐ 12977 Southern Blvd. Ste 200
Loxahatchee, Fl. 33470
Phone: (561)798-8184
Fax: (561) 793-2588

☐ 1025 Military Tr. Ste 209
Jupiter, Fl. 33458
Phone: (561)747- 1987
Fax: (561)747-1313

Medical Record Request

I, _____, request that the following

Facility/Provider: _____

Phone: _____Fax: _____

provide the requested records in writing to: _____

Phone: _____Fax: _____

ITEMS REQUESTED:

- □ OFFICE NOTES-LAST 3
- □ LAB RESULTS-LAST 3
- □ DEXA REPORT
- □ OTHER: _____
- □ X-RAY REPORTS
- □ MRI REPORTS
- □ SLEEP STUDY

I understand that this authorization will be valid for one year, and I may submit a written request to revoke this authorization at any time except whereas the records have already been sent.

_____ _____
Print Full Name Date of Birth

_____ _____
Patient Signature Today's Date