Central Florida Rheumatology Consultants, LLC

Lance Feller, MD, FACR
Board Certified in Rheumatology

**RECORDS RELEASE REQUEST**

To:

☐ **PCP:** ____________________________________________

☐ **Other:**
____________________________________________
____________________________________________

I, ____________________________, hereby request that you release my MEDICAL RECORDS to:

**Central Florida Rheumatology Consultants, LLC**
**915 Harley Strickland Blvd**
**Orange City, FL 32763**
**Phone: (386) 561-9967 Fax: (844) 815-1446**

This includes a report of my diagnosis, treatment, prognosis and recommendations, as well as any other data pertinent to your treatment of me. I request ALL of my records to be sent unless specific dates or specific tests are listed below. Thank you.

- Release records only for the following period.

FROM: _______/_______/________TO: ______/______/_______

: Present ☐

- Release records only for the following test(s) / report(s): (Please Include Dates)

☐ Labs:___________________ ☐ CT Scans:___________________
☐ X-rays:___________________ ☐ Last Visit Note:___________________
☐ MRI:___________________ ☐ Other:
________________________________________
________________________________________
________________________________________

**REASON FOR REQUEST:**

Date of Request____________________________

____________Continuity of care treatment
____________At the Request of individual please include all sensitive information

Patient Printed Name_______________________________ Date of Birth______________________

Patient's Telephone Number__________________________

I understand and give my permission for my records to be sent via facsimile (fax machine).

**Patient Signature:**________________________________ Faxed: _____/_____/______