CARD
Center for Arthritis
& Rheumatic Disease

Medical Record Release Form

Please complete this form and fax to the physician, hospital, or organization from which you are requesting records. This information will then be forwarded directly to our office. Records including clinical notes, labs results, radiology reports, hospitalization summary, immunization, medication lists, etc.

I hereby authorize and request medical records are release from:

Name of Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

To release the following records for the patient:

Patient Name: _____

Address : _____

DOB: _____

SSN: _____

Covering the period of treatment:

From: _____

To: _____

This information is.to be released to:

Huma Shujaat, D.O.

Center for Arthritis & Rheumatic Diseases, PLLC

940 W Stacy Rd Suite 110,

Allen, TX 75013

Phone: 972-696-9943 Fax: 972-472-1679

Signature: _____ Relationship (if not self): _____

Date: _____