Orlando Arthritis and Rheumatology Clinic
7932 West Sand Lake Road, Suite 200
Orlando, FL 32819
PH: 407-355-7759 FAX: 407-355-4987

MEDICAL RECORD REQUEST

Patient Name: __________________________ D.O.B.: ______________________ DOS: _________________

I hereby authorize the release of all medical records in your possession regarding my illness/ treatment as indicated to the requesting physician. I understand that the disclosed information may be subject to re-disclosure by the recipient. Please forward all records to:

Requesting Physician:
Pankaj Bansal, MD
Orlando Arthritis and Rheumatology Clinic. 7392 West Sand Lake Road, Suite 200, Orlando, FL 32819
Phone: 407-355-7757, Fax: 407-355-4987

Authorizing records to be released from:

Name:____

Address: ____

Phone: _______________________________________ Fax: ____

Information to be released:

- □ Progress notes from last 2 visits
- □ Labs
- □ X-ray
- □ Infusion note/report
- □ Echocardiogram
- □ MRI
- □ Hospital / Emergency Reports
- □ EKG
- □ CT Scan
- □ Consultation Report
- □ EMG/NCS
- □ Pathology Report
- □ Other :

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon authorization. The authorization will expire six months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: ___________________________Printed Name: __________________________ Date: _____________