



North Fulton Rheumatology, P.C.

Arthritis, Bone and Connective Tissue Diseases

Ciela Lopez-Armstrong, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

I HEREBY AUTHORIZE NORTH FULTON RHEUMATOLOGY P.C.:

____ Release my medical records to the following person/facility: _____

____ Speak or correspond with the following person or clinician regarding my treatment
At North Fulton Rheumatology P.C.:

Name (or Facility): _____ Phone: _____

Address: _____ Fax: _____

Specify information to be released:

Treatment dates: From: _____ To: _____

Other: _____

____ I HEREBY AUTHORIZE NORTH FULTON RHEUMATOLOGY P.C. TO
REQUEST MY MEDICAL RECORDS FROM:

Name: _____

Address: _____ City, State, Zip Code: _____

Phone: _____ Fax: _____

____ Sent via USPS / ____ Patient pick up / ____ send via Fax

I UNDERSTAND THAT NORTH FULTON RHEUMATOLOGY, P.C. MAY CHARGE A FEE
FOR COPYING AND/OR MAILING MY MEDICAL RECORDS.

Patient Signature _____ Date: _____