



RHEUMATOLOGY CENTER OF SAN DIEGO

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RELEASE OF MEDICAL RECORDS

Today's date: _____

I (**your name**), _____ request and give my permission to release my Medical Record as indicated below from the following Medical Facility: (**name of doctor or medical facility we will be obtaining records from**) _____

_____ to Rheumatology Center of San Diego PC at the above address.

- Most recent lab results AND any immune system lab results, regardless of the date
- Diagnostic testing reports, including X-Rays, MRI, CT of spine and joints, Bone Density (DEXA scan), EMG reports or biopsies
- Progress report from patient's last visit
- Other: _____

Patient's signature

DOB