CARROLL ARTHRITIS, P.A.

412 Malcolm Drive, Suite 306
Westminster, MD 21157

410-848-0364 (phone)
410-848-4037 (fax)

RECORDS RELEASE

Patient: _____

Date of Birth: _____

FOR OFFICE USE ONLY:

To: _____

I hereby authorize you to release the following Protected Health Information to the healthcare providers at Carroll Arthritis, P.A.:

_____

_____

_____

_____

This release expires five (5) years from the date signed.

Patient Signature: _____

Date: _____

Witness: _____