

# RHEUMATOLOGY THERAPEUTICS

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I hereby authorize ..... to release the complete medical records concerning my illness and/or treatment.

To:.....

Phone # ( ).....

Fax # ( ).....

- X-ray results
- Medical Records
- DEXA Results
- Lab results
- MRI Results
- Others\_\_\_\_\_

Date:.....

Please print name:.....

Signature:.....

Date of Birth:.....

Witness:.....