

CARROLL ARTHRITIS, P.A.

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Westminster, MD 21157

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410-848-4037 (fax)

RECORDS RELEASE

Patient: _____

Date of Birth: _____

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: _____