Oldsmar Rheumatology
3684 Tampa Road; Unit 3
Oldsmar, FL 34677
Phone 813-475-6145
Fax 813-475-6156
Kavita Thomas MD

I hereby authorize you to release my medical records. I understand my records may include information relating to alcohol and drug abuse, communicable diseases, HIV testing, and results and psychiatric or psychological conditions.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO: Oldsmar Rheumatology attn. Dr Kavita Thomas

PH: 813-475-6145 **FAX**: 813-475-6156

RECORDS TO BE RELEASED: recent notes, all imaging studies including x-rays, ct scans, MRIs, and all lab work

PATIENT INFORMATION

Patient Name (Print) _____

Social Security # _____ Date of birth _____

_____ _____

(Patient's signature) (Date)

_____ _____

(Witness signature) (Date)

This consent and authorization expires one year from date signed. You may revoke this permission in writing at any time. We are unable to take back any disclosures we have already provided o you