

# MEDICAL RECORDS RELEASE

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NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

I AUTHORIZE \_\_\_\_\_ TO RELEASE  
MEDICAL INFORMATION/RECORDS TO THE FOLLOWING:

NAME OF DR/HOSPITAL \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

FAX#: \_\_\_\_\_

PLEASE SEND THE FOLLOWING INFORMATION:

\_\_\_\_\_ ENTIRE RECORD  
\_\_\_\_\_ RECORDS FROM \_\_\_\_\_ TO \_\_\_\_\_  
\_\_\_\_\_ OTHER \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## FOR OFFICE USE

DR. KALRA APPROVED: \_\_\_\_\_  
AMOUNT BILLED: \_\_\_\_\_  
CASH/CHECK#: \_\_\_\_\_

PICKED UP: \_\_\_\_\_  
MAILED/FAXED: \_\_\_\_\_  
DONE BY: \_\_\_\_\_