

Deepak Raja, M.D. Keshini C. Parbhu, M.D.

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AUTHORIZATION TO REQUEST OR RELEASE MEDICAL INFORMATION

I AUTHORIZE: HEALTHCARE PROVIDER ADDRESS CITY STATE ZIP CODE TO RELEASE TO: NAME OF RECEPIENT ADDRESS CITY STATE ZIP CODE I AM REQUESTING COPIES OF THE FOLLOWING INFORMATION FROM MY MEDICAL RECORD: (Please checkbox below) COMPLETE MEDICAL RECORD X-RAYL LABORATORY TEST (SPECIFY): RECORDS PERTINENT ONLY TO MY ILLNESS: HISTORY AND PHYSICAL EXAM (DATE): H	PATIENT:				
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ADDRESS	Patient Signature:			DATE:	
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CITY STATE ZIP CODE		ADDRESS			
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