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Anthony S. Padula, M.D., F.A.C.R.

RECORDS RELEASE FORM

Date: ____/____/_____

To: _____
(Physician and/or Facility where records are located)

I, _____, hereby authorize you to release any medical records to:

[ ] Rajiv K. Dixit, M.D.
[ ] John M. Loeb, M.D.
[ ] David W. Wu, M.D.
[ ] Rashmi B. Dixit, M.D., PhD.
[ ] Zuzana Foster, M.D.
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Please send the following records:

[ ] All medical records.
[ ] Records dated _____ to present.
[ ] X-ray/Lab reports only.
[ ] Consultation note.
[ ] Other _____

Patient's Name: _____

Patient's Date of Birth: _____/____/_____

Patient's Signature: _____