RECORD RELEASE FORM

Date:_________________________

To: ____ PHONE#____________________
(Physician and/or Facility where records are located)

I, ____________________________________, hereby authorize you to release my medical records to:
(Patient's name) **PURPOSE: CONTINUITY OF CARE**

[ ] Atul Agrawal, MD
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Please send the following records:
[ ] Current chart notes.
[ ] X-ray/Lab
[ ] Consult
[ ] Other:____

Patients Name: (Print)____

Patient's Signature:
____ DOB:_____________

Witness:_____________________