AUTHORIZATION for MEDICAL RECORDS.

I request a copy of the Medical Records for the patient named below. I understand that these records cannot be faxed due to file size and transmission protocols and will be on a thumb drive, ready to pick up from the Fountain Valley Office in five to ten business days.

I have completed the payment for these records on-line.

Name of Patient: _____

Date of Birth: _____

Name of Person Completing this form: _____

Relationship with Patient: _____

Phone: _____

Email Address: _____

Signature: _____ Date: _____

Send completed form to: info@panditmd.com