AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

I hereby authorize and request Lalita Pandit MD., Inc. to fax all my medical records to:

_____

Fax #:

_____

Physician Name:

_____

Address:

_____

City: State: Zip:

Telephone: _____ Fax: _____

Patient Name: _____ Patient Signature: _____

Date of Birth: _____ LAST 4 digits of SSN: _____

Patient Email: _____