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REQUEST FOR RELEASE OF INFORMATION

Patient's Full Name:_____ Date:_____

Address:_____

Patient's Date of Birth:_____ Social Security #_____

Cell #_____ Email :_____

I hereby authorize ARUN A. POL, M.D.,P.C.

__ to communicate verbally with __ to obtain copies from __ to release copies to

Name/Organization:_____

Cell/Phone #_____

Fax# _____

Email:_____

PURPOSE OR NEED FOR RELEASE:

INFORMATION TO BE DISCLOSED:

This authorization and/or request to release protected health information from my medical records is fully understood by me and is made voluntarily on my part and may include faxing or Emailing of medical record information. Fees for copies: Federal and State laws permit a fee to be charged for the copying of records.

Signature of Patient:_____ Date:_____

Or Parent/Guardian if patient is minor under 18 yrs of age