Neeta R. Bhardwaj, M.D., P.A.

Request for Release of Medical Records

To:

Name: ____

Address: ____

Phone Number: ____

Fax Number: ____

I hereby authorize and request you to release the medical records on:

____ ____________________________
Patient's Full Name Date of Birth

____ ____________________________
Patient's Full Name Date of Birth

____ ____________________________
Patient's Full Name Date of Birth

____ ____________________________
Patient's Full Name Date of Birth

Please mail/fax (preferred) records to:

Neeta R. Bhardwaj M.D., P.A.
11710 FM 1960 West, Houston, TX 77065
(281) 469-6097
Fax: (281) 469-7670

Information Needed

______All Information

______Immunizations only

______Operative Report

______ Laboratory Testing

______ Hospital Stay/ER Visit

______Hospital Discharge Summary

____________________________________ __________________________
Patient's (if 18 or older) or Parent's Signature Date

____
Printed name of patient (if 18 or older) or parent

This authorization expires 90 days after signature date.

For office use only:

Date Sent: _____________________________ Staff Name:________________________________