

Neeta R. Bhardwaj, M.D., P.A.  
**Authorization for Release of Medical Records**

I hereby authorize:

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

To provide:

\_\_\_\_\_ All Information

\_\_\_\_\_ Laboratory Testing

\_\_\_\_\_ Immunizations only

**For:**

\_\_\_\_\_  
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

**To:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_  
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: \_\_\_\_\_

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