Medical Record Release

Date: ______________

To: ____________________________

Tel: ____________________________

Fax: ____________________________

I hear by authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me while under your care. This request can only be used from now until one hundred eighty day (180) from the date of signature.

Please send:

Entire chart ________________

Lab/Imaging ________________

Other ______________________

To:

____ Viney Soni, M.D.

____ Neil Soni, M.D.

____ Abhishek Bhardwaj, M.D.

____ Ana Maheshwari, M.D.

9940 Talbert Ave, STE 101

Fountain Valley, CA 92708

Tel (714) 545-8700

Fax (714)545-8084

____

Witness

____

Patient Name (please print)

____

Signature (relation if not patient)

____

Patient's Date of Birth