ACE HEALTH AND WELLNESS CENTER PLLC

Internal Medicine Clinic "*Your health is our priority*"

Isha Gupta MD Jujhar Singh DO Srinivasa Reddy MD,MRCP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I (Patient Name), ____ DOB_____/_____/_____

Authorize, **Physician/Facility Name**: ____

Address:____

City: ____________________________________State: ___________Zip: ___________________

Phone: (_______) _________________________Fax: (______) ____________________________

To release my records to:

☐ Isha Gupta, MD ☐ Jujhar Singh

☐ Srinivasa Reddy, MD

Please include the following:

☐ All Records ☐ Labs, X-Rays ☐ Progress Notes **ONLY**

I request and authorize the above-named doctor or health care provider to release the information specified above to the organization, agency or individual named on this request. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

Patient Signature____Date: ____/____/_____

PLEASE MAIL IF FAX IS MORE THAN 15 PAGES

14815 N Del Webb Blvd.

Sun City, AZ 85351

P) 623-248-1717 F) 623-248-1688