MURTHY GEDALA PLLC

RECORDS RELEASE REQUEST

PATIENT INFORMATION

Frist Name: _____Last Name: _____ MI: _____

Social Security Number: _____ Date of Birth: _____

Address: _____City _____ State _____ Zip_____

I hereby authorize and request the following doctor/facility release the below checked items to Murthy Gedala PLLC.

____ My complete medical record

____ Records of care from timeframe _____ to _____ only

____ Records of care concerning the following condition(s): _____

_____ _____
Patient Signature Date

RECORDS RELEASE FROM:

Doctor/Facility _____

Address _____

Phone Number _____ Fax Number _____