Records Release Form

Date: ____

Attn (To): ____
(Doctor or Hospital)

Address: ____

____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY RECORDS TO:

Dr. Neera Bhatia M.D., P.A.
1303 McCullough Suite 237
San Antonio, Texas 78212
P: 210.222.2694
F: 210.222.2565
drbhatia@neerabhatiaobgyn.com
www.neerabhatiaobgyn.com

PLEASE INCLUDE THE COMPLETE MEDICAL RECORDS IN YOUR POSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD OF TIME FROM ____________ *TO* _____________ .

Patient Information:

Name of Patient: ____________________________________

Date of Birth: ______________________________________

SSN: ____

Signed: ____
(Patient or Nearest Relative)

Relationship: ______________________ **Witness:** ___________________________