AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION				
Last Name:	First Name:		MI:	
DOB:	SS#:	Sex: M ☐ F ☐	Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep	
Address:	City:	State:	Zip:	
Driver's License#:	Home Phone:	Work Phone:		

AUTHORIZATION:

I, _____ authorize _____
Parent's Parent/Guardian **Former Medical Group)**

to release medical information from my medical record to:

Sarasa Kumar M.D.
13768 Roswell Ave., Suite 205
Chino, CA 91710
Tel: (909) 590-7356
Fax: (909) 627-8999

For the purpose of review/examination and further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitation as indicated below:

☐ Entire Record
☐ Specific Information
☐ Old Records from Previous Physicians

I give special permission to release any information regarding:
(initial line(s) below that you grant us permission to release the pertinent information to the above)

☐ Substance Abuse
☐ Psychiatric Mental Health Information
☐ HIV Information

This authorization will automatically expire one year from the date signed. I understood that I may revoke this consent at any time except to the extent that action has been taken in reliance hereon.

Reason for Request: _____

Signed: _____ _____
(If Not Patient, State Relationship)

Witness: _____ Date:_____

For Office Use Only

Received: _____ Completed By: _____

Completed: _____ Fee Paid: _____

Disclosure consisted of: _____