REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: ____

____

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I hereby request and authorize you to release my medical records including any information concerning HIV disease, alcohol or illicit drug use or psychiatric illness to:

Mudit Jain, M.D.
300 NW 70th Ave, Suite 105
Plantation, FL 33317
Ph: (954)-585-6292
Fax: (954)-585-6290

____ All records ____ Specifically the following:

Patient Name: ______________________________________

Date of Birth: ______________________________________

Patient Signature: ______________________________ _______

Date:_________________________