# REQUEST FOR RELEASE
# OF
# MEDICAL RECORDS

**Patient Name:** _____

**Date of Birth:** _____

**Date:**_____

**TO:** _____

_____

_____

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

_____Please send via mail to the above address.

_____Please send via fax to: _____

____ All records ____ Specifically the following:

_____

_____

_____

**Patient Signature:** _____