AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: ____

Name of facility

I, the patient, ____

Print patient's name

Date of Birth: _______/_______/_______

Social Security Number: _______/_______/_______

Request that any and all medical records, inclusive of operative reports, clinical information, laboratory and pathology reports, radiological files and reports, as well as any other information regarding my health and care at any of the above named facilities be copied and released to the following physician:

Kamaldeep Singh, D.C.

I hereby authorize you to release all necessary medical records to the above named physician.

_______________________________________ _____________________

Patient's Signature (If 12 years of age or older) **Date of Signing**

_______________________________________ _____________________

Signature of Patient's Representative **Date of Signing**