Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____
_____
_____

I authorize you to furnish a copy of my medical records to be inspected or copied by

La Vista Clinic
F-17, First Floor THE HIVE,
Sector 102, Dwarka Expressway,
Gurgaon, Haryana-122001
Call: 08588005544

This authorization covers information pertaining to all conditions for which I have received care, including history, physical exam, assessments, diagnosis, laboratory and radiological tests, reports and consultations for the dates of_____through the present. I release you from all legal responsibility or liability that may arise from this authorization. I authorize the use of a telefax or photocopy of this form for the release of the information.

Printed Name_____

Signature_____

Witness_____

Date of Birth_____