Request & Authorization for Release of Medical Records

Name of Patient, (Last & First)	Date of Birth	Social Security #

1. *I hereby authorize* _____(M.D., agency or institution) to furnish all medical information concerning the above named patient to following physician:

(Name & address of receiving physician or person or institution)
Neema Malhotra, M.D. 2730 Union Ave, Ste B, San Jose, CA 95124

Fax Records To #: (408) 650-7417 , Tel: 408-684-8600

2. *I specifically direct that **ALL** OF MY HEALTH RECORDS , EXCEPT* NONE of the following information be released

(check only if applicable) or leave it blank unchecked:

- ☐ **Mental health records**
- ☐ **Drug and alcohol abuse records**
- ☐ **HIV/AIDS test results**
- ☐ **Genetic test results**
- ☐

3. *I understand* that I have the right to receive a copy of this authorization. This authorization to release records will remain effective for ninety (90) days from this date signed.

Patient Signature:_____ **Date:**_____

If Minor, Parent/Guardian Signature: _____ **Date:** _____

Print Name:_____

Please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian/conservator of an incompetent patient
- ☐ Beneficiary/personal representative of deceased patient

SEND ALL RECORDS TO:

NEEMA MALHOTRA, MD

FAX TO: (408) 650-7417

2730 Union Ave, Suite B, San Jose CA 95124

Tel: (408) 684-8600 NeemaMalhotraMD.com uscisClinic.com

doctor@uscisClinic.com

(Pursuant to Civil Code 56.11)