

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**AASHA PEDIATRICS, INC.
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Meena Sathappan, MD

TO: _____

Please send actual copies of the following information to Aasha Pediatrics, Inc.:

- | | |
|--|----------------------------|
| _____ Hospital Chart | _____ X-ray Report(s) |
| _____ Birth Records | _____ Laboratory Report(s) |
| _____ Office Chart | _____ Vaccine Record(s) |
| _____ Records in the chart from previous physicians / facilities | |
| _____ Other: _____ | |

Any and all information may be released, except as specifically indicated below:

Regarding Patient Name	Date of Birth
_____	_____
_____	_____
_____	_____

Signed: _____

Date: _____

Printed Name: _____

Phone#: _____

If not signed by patient, please indicate relationship: _____ Parent or guardian of minor patient
_____ Personal representative of minor patient