Dr. Kunwar Singh
1127 Salem Street
Malden, MA 02148

Patient name ______________ Date of Birth: __________
Address: ____________________ Telephone: ____________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I herby authorize: My previous physician: _________________________
(Address and phone #, fax#) _________________________
____
____

The specific information to be released is for the date's __________ and includes:

Complete medical record ____ test results____ obstetrics information___
Urgent care visit ______ others (specify) ____________________

Authorization for release of sensitive or
Statutorily protected information

The following categories of information will NOT be released from your record unless you indicate your authorization by signing next to the corresponding categories:

_____AIDS /ARC ____ substance abuse _____HIV testing
_____Sexual assault/ abuse ____ alcohol abuse ____ other

This is authorization will remain in effect for 90 days after the above date or as specified: __________, I understand that I may revoke this authorization at any time.

____
Signature or patient

____
date

____
Signature of parent/ guardian

____
date

PLEASE NOTE: medical records cannot be produced upon demand. Normal processing time is 5-7 business days. We cannot release records that you have had released to us from another doctor facility.