AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Doctor/ Practice Name:____

Address:____

Phone:____

Fax:____

I hereby authorize and request you to release all medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS to:

Dr. Boris Karanfilov / Dr. Sumit Bapna
5378 Avery Rd.
Dublin, OH 43016
Phone: (614) 771-9871
Fax: (614) 771-9877

Patient Name:____

Date of Birth:____

Address:____

Signature:____Date:__________________

Witness:____Date:__________________