KOMPAL GADH, M.D.
ADVANCED OB/GYN INSTITUTE

PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS

SECTION I: Patient Information

Name:	Date of Birth:
Address:	Social Security:
Phone:	Reason for leaving

SECTION II: Request for specific items to be released

I request _____ to release the medical information identified below relating to my treatment during these dates: from _____ to _____

___ Cardiovascular reports ___ Emergency room ___ Pathology report ___ Consultation
___ History physical ___ Progress notes ___ Discharge summary ___ Laboratory results
___ X-ray reports ___ EKG Reports ___ Operative report ___ Complete medical records
___ Photography, videotapes, or other digital images ___ Records for Prescription Medications

___ Other (describe) _____

SECTION III: Delivery Method

- Fax to this number: **(954) 889-0027**
  (**NOTE**: Complete medical records will not be faxed)

- Mail to this address
  KOMPAL GADH, M.D., LLC
  601 N. Flamingo RD., Suite 307
  Pembroke Pines. FL 33028

SECTION IV: Release

I hereby release _____, and its employees from any and all liability that may arise from the release of the information as I have directed.

_____ _____
Signature of patient or legal guardian Date