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PERMISSION TO RECEIVE AND RELEASE PATIENT MEDICAL RECORDS

I, _____, give my permission to:
(PRINT NAME)

Dr. A. Maheshwari/Dr. Y. Lee to receive/release my medical records to/from the following doctor(s) facility so that they may be used in order to provide care for me and so that said doctor or facility will have the records needed in order to perform tests that are being requested by Dr. A. Maheshwari/Dr. Y. Lee.

Please clearly print the first and last names and the fax number of any person you will allow us to release/receive documents to/from. Include family if applicable. Dr. A. Maheshwari/Dr. Y. Lee has automatically been added to this list:

FIRST NAME	LAST NAME	FAX NUMBER
YOUNG	LEE, M.D.	951-848-6923
MAHESHWARI	ANOOP, M.D.	951-848-6923

_____
_____
_____
_____
_____
_____

*Patient's Signature:_____
*Print Name:_____
*Today's Date:_____ Expiration Date:_____1 year.
PT #:_____

**I hereby release Dr Dr. A. Maheshwari/Dr. Y. Lee from any/all legal liability that may arise from the release of this information to the party named above. **I understand that I have a right to receive a copy of this authorization upon request and that this authorization will expire exactly 1 year from the date this is signed_____Pt. initials.