Smriti Goel M.D., S.C.

MEDICAL RECORDS RELEASE

_____ _____ _____-_____-_____
(Name of patient) (Date of Birth) (Social Security Number)

Obtain From:

_____
(Physician/Institution)

_____
(Address)

_____
(City, State, Zip)

_____/_____
(Phone) (Fax)

MAIL ONLY (fax upon request)

Smriti Goel, M.D
(Physician/Institution)

707 Lake Cook Road, Suite260
(Address)

Deerfield, Illinois 60015
(City, State, Zip)

(847) 564-0055 / (847)564-0051
(Phone) (Fax)

I would like to obtain the following medical records for the above named person in order to maintain continuity of care for medical practice. Below is a release, signed by the patient.

- ☐ All record (including mental health, alcohol, drug abuse, AIDS/ HIV related info)
- ☐ Discharge Summary
- ☐ Complete Hospital Records
- ☐ Radiology
- ☐ Laboratory Test/Reports
- ☐ Cardiology report/EKG
- ☐ Social History (Mental health, Alcohol, Drug abuse)
- ☐ AIDS/HIV related info
- ☐ Psychiatric conditions and treatment of these Diagnoses
- ☐ Other_____

I hereby authorize any information which you may have concerning my medical care. This Authorization shall remain valid unless revoked but **will expire in 1 year after signing.**

_____ _____ _____
(Signature of patient or /Legal Representative) (Relationship to patient) (Date)

_____ _____
(Witness) (Date)