K.K. Bhatia, M.D., F.A.A.P.

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MEDICAL RECORD RELEASE

Transferring from:______________________________

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Transferring To:______________________________

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Please send copies of the following information:

__Hospital Charts __X-Ray Report

__Birth Records __ Labaratory

__ Office Charts __ Vaccine Record

__Other:______________________________

*Please FAX immunization records ONLY, and MAIL in the remainder of records. Thank you!

Patient name:	Birth Date:
______________	______________
______________	______________
______________	______________

Parent's name and former address:

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I hereby give my request and consent to release the above confidential medical information to assist Dr. Bhatia's office in the diagosis and treatment of my child.

Parent/Guardian Signature______________________________

Witnessed______________________________