UNIVERSAL CLINICAL CARE LLC.
DR.AMAN PATEL

MEDICAL AUTHORIZATION
RELEASE OF MEDICAL RECORDS

You are hereby authorized to release any and all information, records and reports for medical and/or hospital care given to me. Release of said information is to be made to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number:_____ Fax Number: _____

Thank You,

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Patient Signature: _____