Ashok J. Bharucha, M.D. PC

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

I hereby authorize Ashok J. Bharucha, M.D., P.C. to furnish medical information concerning

[patient's name:]_____ to [physician's name and

address:]_____.

Any and all information may be released, including, but not limited to, mental health records, drug and alcohol abuse records, and HIV test results, if any, except as specifically provided below:

_____
_____
_____
_____

This authorization is effective now and will remain in effect for one year, or until

[date:]_____

I understand that I may receive a copy of this authorization.

_____ _____
Signature of patient
(Or patient's personal representative)

Date of receipt

Personal representative information (if applicable):

_____
Name of personal representative

_____
Relationship to patient (or other authority)