Release of Medical Records from us

I hereby authorize the **Sanjay Thakkar, MD, Yorkville Internists, SC, 2720 East New York St., Suite 108, Aurora, IL 60502** to release of my medical records:

_______ All Records   _______ Progress Notes   ________ Lab Tests

_______Diagnostic Test   ______ ---
(Specify)

From_____/____/_____   to _____/_____/_____ and request to send it:
(Date)   (Date)

To: ____
(Doctor / Hospital Name)

Street Address: ____

City: ____________________________ State:____________________ Zip:__________

Phone: ___________________________Fax:__________________________________

Name of Patient: ______________________________ Date of birth ____/_____/_____
Last   Fist   MI   mm   dd   yyy

Signature: ____________________________________   Date _____/_____/_____
Patient or Guardian   mm   dd   yyy

Complete this entire form and send it to our office if you need records to be released from us.