

BABA HEALTHCARE, INC
Geetha Priyanka, M.D.
964 S. WICKHAM ROAD
SUITE 1
W. MELBOURNE, FL 32904
321-956-7370- Phone
321-956-7873- Fax

I hereby authorize: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION
INCLUDING HIV, AIDS, PSYCHIATRIC, SUBSTANCE ABUSE

I hereby authorize the above named physician/hospital/facility to release information including, if any, psychiatric or psychological information_____, infections or contagious disease information (including HIV/AIDS confidential information_____, and or information about drug or alcohol abuse or treatment_____ of same from the health record(s): TO RELEASE MY: _____ COMPLETE MEDICAL RECORD, _____ OTHER (AS DESCRIBED) _____

as soon as possible to BABA HEALTHCARE INC to the address and/or fax number above.

Additional comments: _____

Patient's Signature

Date

Name (Please Print)

Social Security number

Address (Street)

Date of Birth

City, State, Zip Code

Phone number

Witness Signature

Date

Originated 8/6/03