HEART RHYTHM SPECIALISTS OF CALIFORNIA INC.
CARDIOVASCULAR MEDICINE | CARDIAC ELECTROPHYSIOLOGY
SUKHVINDER BHAJAL, M.D.

REQUEST FOR PATIENT RECORDS

DATE ____________________

PATIENT NAME ______________________________DATE OF BIRTH ______________________

I AM AUTHORIZING SUKHVINDER BHAJAL, M.D. TO RECEIVE MEDICAL RECORDS FROM OTHER PARTIES TO ASSIST IN HIS TREATMENT WITH MY CARE.

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AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE YOUR OFFICE TO RELEASEANY TREATMENT INFORMATION REQUESTED INCURRED FOR THE TREATMENT SERVICES OF SUKHVINDER BHAJAL, M.D.

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PATIENT (PARENT OR GUARDIAN IF MINOR) DATE