Dr. NEEL RAYA, MD

Board Certified Internal Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

RECORDS REQUESTED FROM:

PROVIDER/FACILITY NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

I, _____, authorize the above provider or facility to furnish a copy of my medical records dating from _____ through _____ to Dr. Neel Raya as soon as possible. My date of birth is _____ and Social Security Number is _____. I hereby release this provider/facility from all legal responsibilities or liability that may arise from this authorization.

Patient Signature: _____ Date: _____

Printed Name: _____

PLEASE SEND RECORDS VIA:
FAX: 740-653-2791
OR
MAIL: 2658 N COLUMBUS ST. SUITE A. LANCASTER, OH 43130