# PREMIER HEALTH CARE, INC.

**V.L. CHERUKURI, M.D.**
**INTERNAL MEDICINE & GERIATRIC CARE**
**218 PASADENA AVENUE SOUTH,**
**ST. PETERSBURG, FL 33707**
**PHONE: (727) 345-0160 • FAX: (727) 345-0100**

## REQUEST FOR RELEASE OF MEDICAL RECORDS

**To:** _____
**(Physician Name)**

_____
**(Address)**

_____
**(City)** **(State)** **(Zip Code)**

**I hereby request that my medical records be released to:**

**Vijaya Cherukuri, M.D.**
**218 Pasadena Avenue South**
**St. Petersburg, FL 33707**

_____ _____
**(Date)** **(Patient Signature)**

_____ _____
**(Date of Birth)** **(Patient Name Printed)**

_____
**(Social Security #)**

**Records Requested: Progress notes, Labs, X-Rays, Medication logs.**

**I understand that my records may contain information regarding drugs, alcohol, and communicable diseases which are protected by Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the Federal regulations. I also understand that I may revoke this consent at any time. My signature also means that I have read this form and/or have had it read to me in a language that 1 can understand.**