Records Release Authority

To: Medical Records Department ____________________

I, ______________________________ D.O.B: ____________

(Patient's name or Guardian)

Hereby request that you release to:

MANJARI ARAVAMUTHAN, MD

INTERNAL MEDICINE

TEL: (408)929-6922 / FAX: (408) 929-8671

200 Jose Figueres Ave. #230
San Jose, CA 95116

1569 Lexann Ave. #220
San Jose, CA 95121

☐ ALL RECORDS

☐ PROGRESS NOTES, H&P — LAST ☐ 1 YEAR ☐ 2 YEAR ☐ ALL

☐ CONSULTATIONS — LAST ☐ 1 YEAR ☐ ALL

☐ PROCEDURE, BIOPSY, SCANS — ☐ ALL

☐ EKG — ☐ LAST 3 YEARS

☐ OTHER RELEVANT INFORMATION PERTINENT TO MY CARE

____
(Date)

____
(Patient Signature)

____
(Witness)