ohio facial PLASTICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Doctor/ Practice Name:_____

Address:_____

Phone:_____

Fax:_____

I hereby authorize and request you to release all medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS to:

Dr. Sumit Bapna
5378 Avery Rd.
Dublin, OH 43016
Phone: (614) 876-6673
Fax: (614) 876-8674

Patient Name:_____

Date of Birth:_____

Address:_____

Signature:_____Date:_____

Witness:_____Date:_____