

**Authorization to Release Medical Records**

Date \_\_\_\_\_

I, \_\_\_\_\_

(Patient's name)

Hereby request that my medical records be released to:

REKHA BAINS MD PC  
275 VARNUM AVE  
SUITE # 108  
LOWELL, MA 01851

\_\_\_\_\_  
Patient's or guardian's signature relationship

\_\_\_\_\_  
Date of birth social security #

\_\_\_\_\_

\_\_\_\_\_  
Patient's address

\_\_\_\_\_  
Please (circle one): FAX MAIL

Fax #: \_\_\_\_\_