BABA HEALTHCARE, INC
Geetha Priyanka, M.D.
948 South Wickham Rd. Suite 103
West Melbourne, FL 32904
P: 321-956-7370 F: 321-956-7873

I hereby authorize: _____

_____

_____

CONSENT FOR RELEASE OF MEIDCAL INFORMATION INCLUDING HIV, AIDS, PSYCHIATRIC, AND SUBSTANCE ABUSE.

I hereby authorize the above named physician/hospital/facility to release information including, if any, psychiatric or psychological information _____, infections or contagious disease information (including HIV/AIDS) confidential information_____, and or information about drug of alcohol abuse or treatment _____of same from the health record(s): TO RELEASE MY:____ COMPLETE MEDICAL RECORDS, _____OTHER (As DESCRIBED):

_____

_____

_____

as soon as possible to BABA HEALTH CARE INC to the above address and/or fax.

_____ _____
Patient's Signature **Date**

_____ _____
Name (Please Print) **Social Security Number**

_____ _____
Street Address **Date of Birth**

_____ _____
City, State, Zip Code **Phone Number**

_____ _____
Witness Signature **Date**