

ALPHA MEDICAL CLINIC

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Internal Medicine/Geriatrics

Diplomate of the American Board of Internal Medicine

RECORDS RELEASE

DATE: _____

To: _____ (Physician)

Re: _____ (Patient)

_____ (Date Of Birth)

I hereby authorize you to release my Medical records to:

Dr. Dhiraj A. Patel, M.D.
401 South Main Street, Suite A4
Alpharetta, GA 30004

Patient's Signature

Date