



**PURI PEDIATRIC
Medical Group, Inc.**

Diplomate, American Board of Pediatrics

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

Patient/s' Name: _____
(Last) (First) (Middle)

Patient/s' Date of Birth: _____

I hereby authorize the release of medical records concerning the above named patient
from doctor/clinic: _____

Address: _____

To doctor/clinic: _____

Address: _____

Signature: _____
(Parent or guardian of minor)

Print Name: _____

Telephone Number: _____

Please allow approximately 7 to 10 working days to complete your record transfer.