

**ARUNA BAKHRU, M.D.**  
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**Poughkeepsie, New York 12601**  
**Telephone: (845) 463-1044 FAX: (845) 463-1043**

**RELEASE AUTHORIZATION FOR MEDICAL RECORDS**

**DATE:** \_\_\_\_\_

**TO:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **SSN** \_\_\_\_\_

**This is to authorize any physician, hospital, medical attendant, or any other health care provider to furnish to Dr. Aruna Bakhru, M.D., Kandr Building, 22 IBM Road, Suite 104B, Poughkeepsie, New York 12601 any and all information or opinions which may be requested regarding my medical condition or treatment by you.**

**You are further requested to disclose no information to any other persons without written authority from me to do so.**

**Photocopies of this authorization and my signature are acceptable. This authorization is valid for two years from the date of signing.**

\_\_\_\_\_  
**Patient signature**

\_\_\_\_\_  
**Date Signed**