RAYCONDA INTERNAL MEDICINE • J. LAL, M.D. (BOARD CERTIFIED)

6977 Nexus Court, Suite 101
Fayetteville, NC 28304
Phone: [910] 864-7933

Date_____

I _____ (PATIENT), hereby authorize _____ (PHYSICIAN/CLINIC)

at _____ (ADDRESS/ PHONE-FAX NUMBER) to release my medical records to

RAYCONDA INTERNAL MEDICINE
J. Lal, MD
P.O. Box 25217
Fayetteville, NC 28314
ADDRESS SERVICE REQUESTED

_____ (PHYSICIAN/CLINIC) (ADDRESS/PHONE-FAX NUMBER)

Please release the following:

____ History and Progress Notes

____ Recent Evaluation of _____

____ Office Notes, Hospital summaries and Lab results

____ Complete medical record concerning any treatment

____ Other _____

_____ Print Name

_____ Signature

_____ Social Security Number

_____ Date of Birth

_____ Witness

_____ Relationship

****** Please mail medical records ******