



**Apollo Health Care Center**  
2490 Hospital Drive, Suite 212  
Mountain View, CA 94040  
Text: 650- 456-9739  
Phone: 408-900-8077  
Fax: 844-9650-9436

**Gayathri Thiru, MD**  
**Seema Sangwan, MD**  
**Aneri Gupta, MD**  
**Gurpreet K. Padam, MD**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**I hereby authorize:**

**Previous Doctor/Facility:** \_\_\_\_\_

**Ph:** \_\_\_\_\_

**Fx:** \_\_\_\_\_

**To release the following:**

- All Records
- XRay Reports
- Lab Reports
- Other (describe): \_\_\_\_\_

**Dates of Service(s):** \_\_\_\_\_

Please fax all records to:

**Apollo Health Care Center**  
2490 Hospital Drive, Suite 212  
Mountain View, CA 94040

**Records are required for the specific purpose of:**

- Continuation of Care
- Change of Insurance or Physician
- Referral
- Other: \_\_\_\_\_

- I understand that my authorization will remain effective from the date of my signature and will expire 30 days after the signature
- The information will be handled confidentially and in compliance with all applicable federal laws
- I understand that I may see the information that is sent
- I understand that I may revoke authorization at any time by written, dated communication

**I have read and understand the nature of this release:**

**Patient Name (printed):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please Note: A copy fee may be charged for medical records.**