Dr.Subroto Kundu

3555 Keith St NW. Suite 211
Cleveland, TN 37312

Phone: 423-790-1529
Fax: 423-790-1589

Healthcare Release

Patients Name: _____

Date of Birth: _____

Social Security: _____

We are requesting records for the above named in order to further treat this patient.

Doctor/or Facility: _____ **Phone:** _____

Address: _____ **Fax:**_____

☐ All Healthcare Information

☐ Consult Notes

☐ All Tests, X-ray's, Labs Etc.

☐ Other: _____.

I authorize the named healthcare provider to release the information or records specified upon request to

Dr. Subroto Kundu
Fax: 423-790-1589
Or Mail: 3555 Keith St.NW
Suite 211 Clevleland,Tn.37312

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization any time by writing to the healthcare provider or to Dr. Kundu.

Print Patient Name: _____

Signature: _____ Date: _____

Legal Guardian/POA:_____