Sudeshna Dasgupta, MD, MPH
Integrative Medicine

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Authorization To Release Confidential Information:

Name of Patient: _____ Date of Birth: _____

I, _____, hereby authorize Dr.Sudeshna Dasgupta, At Integrative Medicine, to release, disclose or discuss my confidential information regarding my treatment, evaluation, assessment, and/or healthcare with the office named below:

Name of Practice: _____

Address: _____

City: _____ State: _____Zipcode: _____

Phone: _____ Fax: _____

It is my understanding that my information will be released to the practice above, for the purpose of: _____. I also understand that this release of information may be revoked at any time and will expire in 6 months from the date below:

Authorized Signature: _____ Date: _____

Print Name: _____ Relationship to patient:_____