Sudeshna Dasgupta, MD, MPH
Integrative Medicine

1000 Centre Park Drive Asheville, NC 28805 Phone: 828-505-2108 Fax: 828-505-7235

Authorization To Release Confidential Information:

Name of Patient: _____ Date of Birth: _____

I, _____, hereby authorize that _____'s medical records or other healthcare information, including intake forms, chart notes, reports and other written information concerning my health and treatment be released from the following practice:

Sudeshna Dasgupta, MD, MPH
1000 Centre Park Drive
Asheville, NC 28805
Phone: 828-505-2108 Fax: 828-505-7235

And be released to the following person:

Name: _____

Address: _____

City: _____ State: _____Zipcode: _____

Phone: _____ Relationship to patient:_____

I understand that this release may be revoked at any time and will expire in 6 months from the date signed below:

Authorized Signature: _____ Date: _____

Print Name: _____Relationship to patient:_____