Name: KAZIR KHAN

Blood Center: Blood Center D

Treatment Center: Sunrise Treatment Center

Block: West Wing

Room No: Room 401 (Dr. Rajeev Khanna)

Doctor Address: 55 Street

I, KAZIR KHAN, give my consent to the above-mentioned Blood Center to share my health and treatment-related details with the appropriate Treatment Center, if required. I understand the purpose of this and agree to the terms voluntarily.

Signature: _____

Date: 20/05/2025