Name: KARAN

District: Aligarh

Blood Center: Blood Center C

Treatment Center: Era Center

Block: BLOCK Z

Room No: Room 545

Doctor Name: Dr. Kirti Saran

Doctor Address: Chowk

I, KARAN, 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