Andersen ORTHOPEDICS
A Professional Corporation

5924 Stoneridge Drive, Suite 103
Pleasanton, CA 94588
www.andersenorthopedics.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

I hereby request and authorize _____to release of the healthcare information of the above patient to the following:

Dr. Lucille B. Andersen

Andersen Orthopedics, A Professional Corporation

5924 Stoneridge Drive, Suite 103

Pleasanton, CA 94588

FAX: 925-553-7310 PHONE: 925-400-6900

This request and authorization applies to:

☐ All Medical Records

☐ Records dating from _____ to _____

☐ Other: _____

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Andersen Orthopedics, APC in writing.

Unless revoked earlier, this authorization expires in 1 year unless I specify another time: _____

Patient Signature: _____ Date: _____

Patient Representative: _____ Relationship to patient: _____