DR. JEFFREY ANDERSON, M.D.
Orthopedic Surgery

Authorization to Release Medical Records

Date of Request: _____

Patient Name: _____ **DOB:** _____

I hereby authorize:

Drs. Anderson & DellaMaggiore, M.D.
333 O'Connor Drive San Jose, CA 95128
P: (408)297-3484 F: (408)292-6481

____ **TO DISCLOSE INFORMATION TO:**

____**TO RECEIVE INFORMATION FROM:**

NAME OF PROVIDER: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

INFORMATION TO BE DISCLOSED INCLUDES COPIES OF:

____ Progress/Chart notes
____ Billing Statements
____ All Medical Records
____ X-Ray/Radiology Reports
____ X-Ray/Radiology CD(s)

The dates for information to be released will be from _____ to _____.

This authorization will be in effect 6 months after the date signed or unless cancelled in writing. I understand the cancellation will have no effect on the information released prior to cancellation. A copy of this authorization is as valid as the original.

Patient Signature: _____ Date: ____/____/_____

Guardian Signature (if patient is a minor): _____ Date: ____/____/_____

Guardian's Printed Name: _____