Webster Orthopedics

Experience. Excellence.

AUTHORIZATION TO RELEASE RECORDS

I HEREBY AUTHORIZE AND REQUEST

_____

_____

_____

TO RELEASE: ☐ MEDICAL RECORDS ☐ X-RAY ☐ OTHER FROM

PERIOD _____ TO _____

PATIENT NAME:_____

DATE OF BIRTH: _____/_____/_____

S.S. # / I.D. # _____

Phone Number: _____

Where would you like your records sent?

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

In what format would you like your records? Disk:_____ Paper:_____

SIGNATURE:_____

(PARENT OR GUARDIAN IF PATIENT IS A MINOR)

DATE:_____

WITNESS:_____

MAIL TO: Webster Orthopedics
Attn: Medical Records
3315 Broadway
Oakland, CA 94611
FAX TO: (925) 838-2481