Authorization of Release of Records

To whom it may concern:

Please forward a copy of:

☐ The entire Medical records

☐ Only these specific items:

....

....

....

To:

Medical Records

Elite Medical Services

39120 Argonaut Way, STE 706

Fremont, CA 94538

Phone: (510) 556-1000

(510) 878-4444 HIPAA-Complaint Facsimile

Patient's Name: ______________________ DOB: ___/___/19___

_____________________________________ ___/___/201___

Patient (Or legal Guardian) Signature *Date*

_____________________________________ ____________________

Print Name of Person signing *Relationship to Patient*

Elite MEDICAL

www.EliteASC.com

(510) 556-5000