Authorization of Release of Records

To whom it may concern:

Please forward a copy of:

The entire Medical records

☐ Only these specific items:

☐ .....

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To:

Medical Records
Elite Surgical 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® Surgical
www.EliteASC.com
(510) 556-5000