

Authorization for Release of Medical Records

Patient Information

Name: _____ Date of Birth _____

Address: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

THE ANDERSON CLINIC, INC.

2445 Army Navy Drive
Arlington, VA 22206

or

2501 Parkers Lane
Suite 200
Alexandria, VA 22306

To:

Name: _____

Address : _____

Telephone: _____

FAX: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____

Date: _____