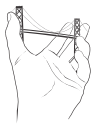

the hand center
OF SAN FRANCISCO

RECORDS REQUEST

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ authorize the release of the following records:

☐ **Medical Notes** ☐ **Laboratory/Study Results** ☐ **X-Rays** ☐ **Operative/Procedure Reports**

☐ **Other** _____

Related to my medical care provided by: _____

Address: _____

Telephone: __(_____)_____ Fax: __(_____)_____

To be forwarded to **The Hand Center of San Francisco, Inc.** at the address listed here (601 Van Ness Ave., Suite 2018, San Francisco, California 94102), or faxed to 415-359-1925, for purposes of continuation of medical care and/or consultation. I accept financial responsibility for any customary costs incurred in this transfer.

DOB / /	SSN - -	MRN
Legal Guardian Name (printed)		Phone Number ( )

_____

LEGAL GUARDIAN SIGNATURE

_____

PATIENT SIGNATURE PRINTED NAME DATE

Kyle D. Bickel, M.D.

601 Van Ness Ave, Suite 2018 • San Francisco, California 94102 • (415) 751-HAND • fax (415) 359-1925 • admin@sfhand.com • www.sfhand.com