Robert E. Anderson

361 Hospital Road, Suite 333
Newport Beach, CA 92663
Ph: (949) 642-8727 Fax (949) 642-5413

Medical Records Release Request

(To be filled out by patient and returned to Southern California Reproductive Medicine via fax or email.)

Date:

To: (Name and address of your Physician)

Address: Office Phone #

Office Fax#

I hereby authorize you to release my record to:

Robert E. Anderson, M.D.

Please send to: ☐ **361 Hospital Road, # 333**
Newport Beach, CA 92663
Ph: (949) 642-8727
Fax: (949) 642-5413

Records to be Included:

Records to be excluded:

Expiration Date of Authorization
This authorization is effective through: s revoked or terminated by the patient or
the patient's personal representative.

Potential for Re-disclosure
Information that is disclosed under authorization may be disclosed again by the person or organization to which
it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (Print or Type) D.O.B. Social Security #

Signature of Patient Date

Signature of Patient Representative Name of Patient Representative and Relationship (Print or Type)

NOTE: If you wish to fill out and sign this form electronically, you must have Adobe XI.

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