NORTHERN CALIFORNIA ARTHRITIS CENTER
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RECORDS RELEASE FORM

Date: ____/____/_____

To: ____
(Physician and/or Facility where records are located)

I, ____, hereby authorize you to release any medical records to:

[ ] Rajiv K. Dixit, M.D., F.A.C.P.
[ ] Zuzana U. Foster, M.D., F.R.C.P.(C)
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Please send the following records:

[ ] All medical records.
[ ] Records dated _________________ to present.
[ ] X-ray/Lab reports only.
[ ] Consultation note.
[ ] Other ____________________________________

Patient's Name: ____

Patient's Date of Birth: _____/____/_____

Patient's Signature: ____