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**MEDICAL RECORD RELEASE REQUEST**

To Dr. Anderson:

Please  email,  fax, or  mail paper or CD (possible fee), a copy of my medical record to:

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**RECIPIENT'S NAME**

**FAX NUMBER/EMAIL**

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**MAILING ADDRESS**

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**CITY**

**STATE**

**ZIP**

Below is my personal information.

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**PATIENT'S FIRST NAME**

**PATIENT'S LAST NAME**

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**DATE OF BIRTH**

**SSN**

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**CONTACT NUMBER**

**EMAIL (OPTIONAL)**

\_\_\_\_ (Initial) I realize and understand that email/CD is not secure and my private health records could be seen by others. The office will password-protect the file using my Date of Birth as the password as a courtesy for my protection.

SINCERELY,

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**PATIENT'S SIGNATURE**

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**DATE**

**FEES FOR PATIENTS OBTAINING MEDICAL RECORDS**

- One time no charge if less than 50 pages (ex. Op report/ MRI report only), each additional request is \$30
- \$20 if the chart is at an offsite storage facility – patient who had no appointment after 2004, no rush request
- \$30 for 50+ pages mailed or \$15 for CD
- We required 5 working days to complete the request, additional \$10 fee if records need to be rushed.

\*\*\*\*There may be a fee for the shipping and handling\*\*\*\*

We do not store films of MRI or X-rays that were done at the other facilities. Please contact the facility directly.