

MEDICAL RELEASE FORM

I, _____ authorize the release of any and all of my medical records, x-rays and/or any other forms of medical studies to:

(Please select one)

Release medical information to: East Bay Sports Medicine
1800 Sutter Street, Suite 100
Concord, CA 94520

Release medical information to: _____

Print Patient Name

Date

Signature (patient, parent or guardian)

Date