

**Request for Medical Records**

**Metropolis Medical, PC**

U. Frtiz Bredeek, MD  
Kathy Jordan, MD  
Rudy Guadron, NP  
Lavina Powell, MA

Patient:

Address:

Tel:

I hereby authorize:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Telephone and Fax

To furnish my complete medial history including immunization records, labs, radiology reports and chart notes.

\_\_\_\_\_ **By initialing here, I also authorize the release of all HIV related medical records including labs, radiology reports, chart notes and immunization records.**

Please send records to:

**Metropolis Medical, PC  
Attention: Records  
2351 Clay Street, Suite 512  
San Francisco, CA 94115**

**X** \_\_\_\_\_

**If sending by fax, please call the Office Manager at 415-292-5477 ext. 484 for a secured private fax line.**