CALIFORNIA ORTHOPAEDIC SPECIALISTS

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:__________________________________ Date of Birth:___________________

Phone Number:_________________________

Information being requested:

☐ Medical Records ☐ Billing Records ☐ X-ray Imaging

☐ Other:____

☐ All Dates ☐ Specific Date Range:__________________________

Physician/Facility:____

Phone:____________________________ Fax:_______________________________

Release records to:

Attention:___________________________________ Phone Number:______________________

☐ Fax:_______________________________

☐ Email:____________________________________ (records can only be emailed to the patient)

☐ Address:____

☐ CD ☐ Paper Copy ☐ USB Drive

I authorize the release of my medical information to the recipient listed above. This authorization will expire six months from the date of this notice. I may revoke this authorization at any time, but I must do so in writing to the address listed above. You will be contacted by our office if a fee is required to process your medical record request.

Signature:______________________________________ Date:____________________

Record requests for California Orthopaedic Specialists should be directed to Ocean via email at odejesus@calortho.org or by fax 949-759-5017.