CENTRAL COAST ORTHOPEDIC MEDICAL GROUP

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE SEND A COPY OF THIS RELEASE WITH REQUESTED RECORDS

PATIENT INFORMATION (PLEASE PRINT AND PROVIDE COMPLETE INFORMATION)

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY/ZIP	PHONE

RELEASE FROM – NAME OF PHYSICIAN OR FACILITY RELEASING INFORMATION

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS FROM:

PHYSICIAN/FACILITY		
ADDRESS	CITY/ZIP	PHONE

RELEASE TO – NAME OF PHYSICIAN OR FACILITY REQUESTING INFORMATION

PLEASE SEND MY RECORDS TO:

PHYSICIAN/FACILITY		
ADDRESS	CITY/ZIP	PHONE/FAX

TYPE OF RECORDS TO BE RELEASED:
□ MEDICAL RECORDS □ IN-HOUSE X-RAYS ON CD

REASON FOR RELEASE OF INFORMATION:
□ CHANGE OF INSURANCE □ TRANSFER OF CARE □ PERSONAL FILE □ MOVING OUT OF AREA □ SPECIALIST
□ LEGAL □ OTHER_____

Please allow 15 days for processing. Incomplete information will delay processing.
****FEE MAY APPLY—The medical records department will be in contact with you.

CONSENT:

I authorize the release of all information, and am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol consumption and or abuse.

DATE:

SIGNATURE OF PATIENT, PARENT, GUARDIAN, CONSERVATOR, OR PATIENT POWER OF ATTORNEY **(PLEASE CIRCLE ONE)**

DATE:

WITNESSED BY:

THIS CONSENT IS VALID FOR 90 DAYS. IT MAY BE REVOKED BY THE SIGNER AT ANY TIME.