Orthopaedic Associates of Southern California

14642 Newport Ave #105 Tustin, CA 92780
11180 Warner Ave #161 Fountain Valley, CA 92708
145 S. Chaparral CT #101 Anaheim, CA 92808
PHONE: 949-688-0958 | **FAX**: 949-688-0960

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for: Copies of Medical Record ❑ Paper ❑ Electronic-Portal Only

Patient Information

Patient Name:
(Last Name) (First Name)
Date of Birth: Phone:
Address:
City: State: Zip:

Release To Request From

I authorize Orthopaedic Associates of Southern California to Release / Request Medical Records

Release To: ❑ **Request From:** ❑

Person / Organization:

Address:

City / State / Zip:

Phone: Fax:

Purpose

For the following:

❑Continuing Care
❑Insurance
❑Legal
❑Personal Use
❑Other: _____

_____

Information to Release

Treatment Dates: _____

- o History and Physical Report
- o Emergency Record
- o Billing Record
- o EKG/ECHO
- o Radiology Report
- o X-ray Images CD
- o Other (*Please Specify*) _____
- o Outpatient/ Clinic Record - Clinic / Provider Name:
- o Discharge Summary
- o Operative Report
- o Laboratory Report
- o Pathology Report
- o Consultation Report

State / Federal Laws require specific authorization to release the following types of information:

- o Mental Health
- o Alcohol / Drug Abuse
- o HIV test results

A separate authorization is required for psychotherapy notes.

Fees

Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.

Delivery Instructions	❑ Mail records directly to person or organization specified ❑ Call Requestor when records are ready for pick up I authorize _____ to pick up my medical record copies. Relationship to patient: _____
Notice of Rights	I understand that: 1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment. 2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. 3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to **Orthopaedic Associates of Southern California 14642 Newport Avenue Suite 105 Tustin, CA 92780, 11180 Warner Avenue Suite 161 Fountain Valley, CA 92708, 8245 E. Monte Vista Rd., #200 Anaheim, CA 92808.** 4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. 5. I have a right to receive a copy of this authorization. 6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless otherwise specified:
Signature	Signature: _____ Date: _____ *(Patient, Power of Attorney for Healthcare or Legal Representative)* Legal Representative Relationship: _____

Office Use Only

Completed By: _____

Date: _____