Orthopaedic Associates Of Southern California
14642 Newport Ave Suite 105 Tusitn, CA 92780
11180 Warner Avenue Suite 161 Fountain Valley, CA 92708
710 N. Euclid ST. STE# 202 Anaheim, CA 92801
420 E. 3rd Street Suite 910 Los Angeles, CA 92708

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Date:______________________________ Medical Record#:_______________________ (For office use)

Patient Name (Please print):_____________________________ ,________________________________

Last Name First Name

Address:____

Date of Birth:______________________ Telephone Number:_________________________________

AUTHORIZATION:
I hereby authorize **Orthopaedic Associates Of Southern California** to release information of my health information to the person/organization specified below:

- ❑ Name:____________________
- ❑ Name:____________________
- ❑ Email:__________________________________
- ❑ Name:___________________

Fax to:_______________________

Name

____

Address

____ _______________ __________________

City State Zip Code

Release information regarding:

- ❑ Radiology Reports (MRI, CT Scan, X-ray, Dexa Scan, E
- ❑ All Medical Records
- ❑ Progress Notes
- ❑ Lab Test Reports
- ❑ Physical Therapy Reports
- ❑ Surgery Reports
- ❑ Other (Specify):____

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Patient Name (Please print):_____________________________ ,________________________________

Last Name First Name

**The medical information/records will be used for the following purpose:

____

**If moving, please provide new mailing address:

____

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This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment

[ ] Limited to the following medical information:____________________________________

DURATION:

This authorization shall be effective immediately and remain in effect until ______________________

DATE

RESTRICTIONS:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I have been advised of my right to receive a copy of this authorization.

____ ________________________________

Signature of Patient or Patient's Representative Date

____

Print Name and Relationship to Patient

******Please allow 7-10 business days for processing******

Orthopaedic Associates Of Southern California

OFFICE USE ONLY

Received by:____Date Processed _______________ NOTES :

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