

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize and request
(Patient Name- Please Print) _____ M.D. to release the following information:

- _____ My entire OANC medical record and history of care.
- _____ Portion(s) of my medical record for the period of _____ to _____.
- _____ Physicians chart notes.
- _____ Hospital Records.
- _____ Copy of MRI CD.
- _____ X-rays regarding my (body part) _____
- _____ My x-rays from _____ to _____

Original x-rays are the property of Orthopedic Associates and must be returned within 60 days. Please state which doctor films are being taken to, for return purposes.

To: **Doctor** _____
Name _____
Address _____

_____ **X** _____
Date Signature

Relationship to patient _____

Patients Date of Birth _____

Patient's Social Security Number _____

Patients Telephone Number _____

According to California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.