



1600 Esplanade, Suite C ● Chico, CA 95926
(530) 897-4500 ● Fax (530) 897-4544

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.

_____ 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 30 days.

To: PT/MD _____
Name

Address

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.