AUTHORIZATION TO RELEASE RECORDS TO CALIFORNIA PACIFIC ORTHOPAEDICS

Patient Name: _____ **Birthdate**: ____/_____/_____

Treatment Date(s):_____

Information to be released from:

_____

_____

_____

Information to Be Released:

☐ Physician Note(s) ☐ CD of In-Office X-ray/MRI/Ultrasound ☐ Image Report(s)
☐ Operative Report(s) ☐ Other (please specify)_____

This authorization is effective immediately and is subject to revocation at any time, except that action has already been taken. Otherwise, the **authorization expires 90 days from the date of signing**. I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign.

In addition to the above records, I consent to the release of records including those of:

Drug / Alcohol / Substance Abuse	____ (initial)
Psychiatric / Mental Heath	____ (initial)
Tests for Antibodies to HIV	____ (initial)
AIDS Diagnosis / Treatment	____ (initial)

I further release my attending physician, consultants, the facility and employees from any liability arising from the release of information to the person(s) / agency designed above.

I understand that I have the right to receive a copy of this authorization upon my request.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Please send records to:

CALIFORNIA PACIFIC ORTHOPAEDICS

3838 California Street, Suite 715, San Francisco, CA 94118
3838 California Street, Suite 516, San Francisco, CA 94118
3838 California Street, Suite 108, San Francisco, CA 94118
1099 D Street, Suite 105, San Rafael, CA 94901
Phone: (415) 532-8310 Fax: (415) 752-2560

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