AUTHORIZATION FOR MEDICAL RECORDS RELEASE

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

Dates of service(s): _____

Information to be released from:

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

John P. Belzer, MD	Christopher V. Cox, MD	Mark I. Ignatius, DO	Adrian J. Rawlinson, MD	James Aicardi, PA-C
Peter W. Callander, MD	Jon A. Dickinson, MD	James D. Kelly, MD	Mark A. Schrumpf, MD	Ruth Kershaw, PA-C
Keith W. Chan, MD	Keith C. Donatto, MD	Robert E. Mayle, MD	Frank H. Valone, lll, MD	Katherine Reiswig, PA-C
Charles F. Clark, MD	W. Scott Green, MD	H. Relton McCarroll, MD	Lindsey C. Valone, MD	Johnna Walker, PA-C
				Anji Yang, PA-C

Information to Be Released:

□ Physician Note(s) □ 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 1 year 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.

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.

I agree to pay the following: ● For Records - $0.25 per page ● For In-Office Images - $25.00
● Minimum of $5.00 when using credit cards (not applicable to debit cards)

Patient Signature: _____ **Date**: _____

Guardian Signature: _____ Date: _____

Relationship to Patient: _____

□ **Urgent Request**

- **Pickup at 3838 California St, Ste 715, San Francisco, CA 94118**
- **Pickup at 1099 D Street, Ste 105, San Rafael, CA 94901**

□ **Non-Urgent Request - Mail to:**_____

_____

_____

Completed by California Pacific Orthopaedics Staff Only:

Released by: _____ I.D Checked: _____ Date Released: _____

Total Amount Paid: $_____ Paid by: ☐ Cash ☐ Credit Card ☐ Debit Card ☐ Check