Southern California
Bone & Joint Clinic

Authorization to Release Medical Information

1. I AUTHORIZE: **(Patient's Name)**

_____
Patient's name

_____
Patient's Date of Birth

_____
Street Address

_____
City State Zip Code

2. TO RELEASE MEDICAL INFO TO: **(Whoever you authorize to receive your medical information, e.g. Family member, Parent or Guardian for minors, School's Athletic Dept, Primary Care Physician)**

_____
Name of receiving person/organization

_____
Recipient's Date of Birth

_____
Street Address

_____
City State Zip Code

3. **INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other:_____

4. **RECORDS FROM THE TIME PERIOD:** / / through / /

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

6. Unless otherwise noted, I understand that this authorization shall be valid for o year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Signature of Patient/Guardian for minor: _____Date: _____

Phone (Home): _____ Phone (Cell): _____ Phone (Work): _____