CALIFORNIA
ORTHOPEDICS & SPINE

Phone: 415-927-5300 Fax: 415-493-2542

Medical Records Release

I _______________________________________ (print name) request the release of my medical records to the following:

☐ Pick Up Name: ____

☐ Fax ATTN: ____

Fax #: ____

☐ Mail Name: ____

Mailing Address: _____________________________________

____

____

Records being requested:

☐ Clinic Office Notes ☐ MRI Images on Disc ☐ MRI Report ☐ X-Ray Image on Disc

☐ Other: ____

Date: _________________

I hereby authorize the use or disclosure of my health information:

Patient/Representative Signature: ____ Date: ____________

Relationship if other than patient: ____

Date of Birth: ______________________ Phone Number: ____________________

PHOTO ID IS REQUIRED

Initial Record Request Fee: $0.00 ***Additional Record Requests: $15.00 each***