AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

THIS FORM MAY BE DROPPED OFF AT ANY OF OUR LOCATIONS, FAXED WITH A SIGNED CREDIT CARD AUTHORIZATION FORM, OR MAILED WITH PAYMENT (CHECK OR CREDIT CARD AUTH FORM) TO:

Golden State Orthopedics & Spine
Attn: Medical Records Department
2405 Shadelands Drive, Suite 300
Walnut Creek, CA 94598
Phone: (925) 939-8585 | Secure Fax: (925) 933-4932

I request and authorize Golden State Orthopedics & Spine to release medical information of the patient named below:

Name: _____ **Date of Birth:** _____/_____/_____

Last 4 of SS#: _____ **Phone #:** _____

INFORMATION REQUESTED: ***Fees must be paid for GSOS to process this request. No Records will be copied if fees are not paid.***

☐ **Chart Records (paper copy) $20**	☐ **CD of Images (with copy of reports) $15**	☐ **Chart Records and CD $35**
**Processing Time: 7-10 Business Days	**Processing Time: 5 Business Days	**Processing Time: 7-10 Business Days

Records/Images to be released:

☐ All ☐ Specific Date(s): _____ ☐ Specific Body Part(s):_____

I understand that any and all medical information may be released, including but not limited to mental health, drug and alcohol use, HIV/AIDS test results, and any other records protected by State or Federal laws.

I request that release of medical information be restricted to the following portion of my medical records:

_____

RELEASE RECORDS TO (where and how records should be sent):

☐ **Mail Records** **Name/Company:** _____

Address: _____

City: _____ **State:** _____ **Zip Code**: _____

☐ **Pick up in person** **Select office location where records will be picked up:**

(Photo ID Required) ☐ Brentwood ☐ Concord ☐ Dublin ☐ Oakland ☐ San Ramon

☐ Walnut Creek (2405 Shadelands) ☐ Walnut Creek (2625 Shadelands)

Person authorized to pick up records (if not patient): _____

☐ **Fax Records**

(Chart Records Only) **Name:** _____ **Phone #:** _____ **Fax #:** _____

SIGNATURE: ***This consent will expire 90 days after date of signature and is not valid without signature of patient/authorized representative***

_____ _____ _____

Patient/Representative Signature **Patient/Representative Name (Print)** **Date**

FOR OFFICE USE ONLY:

FEE PAID: AMT $ _____ **DATE:** _____ **INIT:** _____

Pt Called (P/u only): Date_____ Init _____ Mailed/Faxed: Date_____ Init _____ Picked-up (ID Verified): Date _____ Init _____Patient/Representative Signature (Pickup only): _____ Date: _____