GOLDEN STATE ORTHOPEDICS & SPINE

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 AUTHORIZATION FORM) TO:

Phone: (925) 939-8585 | Secure Fax: (925) 933-4932

Golden State Orthopedics & Spine
Attn: Medical Records Department
2405 Shadelands Drive, Suite 300
Walnut Creek, CA 94598

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
**Processing Time: 7-10 Business Days

☐ CD of Images (with copy of reports) $15
**Processing Time: 5 Business Days

☐ Chart Records and CD $35
**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 to Name/Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ Pick up in person **(Photo ID Required)**

Select office location where records will be picked up:

☐ Brentwood ☐ Capitola ☐ Concord ☐ Dublin ☐ Los Gatos ☐ 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: _____