



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 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 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
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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: _____



GOLDEN STATE ORTHOPEDICS & SPINE

CREDIT CARD PAYMENT FORM

Patient Name: _____

Invoice #: _____

Payment Amount: \$ _____

Credit Card Type: Amer Express Discover MasterCard Visa

Name on Credit Card: _____

Credit Card Number: _____ Exp Date: _____

Security Code: _____

ON BACK OF CARD

ADDRESS

ADDRESS LINE 1

ADDRESS LINE 2

CITY

STATE

ZIP

FOR OFFICE USE ONLY. PATIENT DOES NOT COMPLETE THIS PART.

Name of Person Calling: _____

Relationship to Patient: Self Spouse Other

Patient NextGen Account Number: _____

What is Payment For?

Payment on Acct Surgery Deposit Forms /Medical Records Imaging

Taken By: _____ Date: _____