



Corona-Temecula Orthopaedic Associates
MEDICAL GROUP

MEDICAL RECORDS REQUEST

DATE
PATIENT NAME (Last, First, Middle Initial)
BIRTHDATE / /

AUTHORIZATION FOR RELEASE

I authorize the use or disclosure of the above named health information for the purpose of treatment, payment or healthcare operations. Please provide copies of the following records.

- History & Physical, MRI Reports, Discharge Summary, Operative Report, Lab Reports, Other, ER Report, Clinical Progress Notes, Other, X-Ray Reports, Consultation, Other

FROM

DATE OF SERVICE(S) BEGINNING ENDING
PHYSICIAN NAME HOSPITAL NAME PATIENT
ADDRESS CITY STATE ZIP
OFFICE PHONE NUMBER FAX NUMBER

TO

DATE OF SERVICE(S) BEGINNING ENDING
PHYSICIAN NAME HOSPITAL NAME PATIENT
ADDRESS CITY STATE ZIP
OFFICE PHONE NUMBER FAX NUMBER

This authorization is effective immediately and will remain effective until... I understand that the requester may not furnish, use or disclose the medical information unless another authorization is obtained from me...

- Pick Up, Faxed, Mailed

All Request for medical records and copies of x-rays are subject to a fee. This fee is due prior to mailing or picking up the medical records or x-rays.

I also understand that I have a right to receive a copy of the authorization upon request. Copy requested and received Yes No

SIGNATURE OF PATIENT/GUARDIAN DATE

RECORDS REVIEWED BY

PHYSICIAN SIGNATURE DATE

MEDICAL RECORDS SENT

- History & Physical, MRI Reports, Discharge Summary, Operative Report, Lab Reports, Other, ER Report, Clinical Progress Notes, Other, X-Ray Reports, Consultation, Other

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