Corona-Temecula Orthopaedic Associates
MEDICAL GROUP

Date: _____

MEDICAL RECORDS REQUEST

Patient Name: _____ **Date of Birth**: _____

Date(s) of Service Requested: _____

Provider or Department Requested: _____

I authorize the release of the following health information:

☐ *Consultation*	☐ *History & Physical*	☐ *Lab Report*	☐ *Office Note*
☐ *ER Report*	☐ *X-ray Report*	☐ *Operative Report*	☐ *Other:* _____
☐ *Nurse's Note*	☐ *Physician Progress Note*	☐ *Discharge Summary*	☐ *Other:* _____

Term: *This authorization is effective immediately and will remain in effect for 1 year unless otherwise specified. I understand that all record requests require my authorization and that I may receive a copy of the authorization upon request.*
Alternate expiration date: _____ *Copy of authorization requested* ☐

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS or mental health will be disclosed:

_____

Redisclosure: *I understand that once my health care provider discloses my health information to the recipient identified below, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.*

Refusal to sign/right to revoke: *I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my healthcare provider. Any revocation will be effective immediately upon my healthcare provider's receipt of my written notice, except that it will not have any effect on any action taken by my healthcare provider in reliance on this Authorization before the provider received my written notice of revocation.*

Fees: *Federal and state laws permit a fee to be charged for the copying of patient records. I understand that any applicable fees for copies of records must be paid before records are mailed or picked up.*

Photocopy: *A photocopy, fax or electronic copy of this Authorization shall be considered as effective and as valid as the original.*

Please forward records to:

_____
Patient Signature (Or legal guardian if patient is a minor)

_____
Date

_____
Physician Name / Hospital Name / Other

_____
Address

_____
City, State, Zip

_____
Phone Number

_____
Fax Number

OFFICE USE ONLY
Completed by: _____
Date: _____

341 Magnolia Avenue, Suite 101 • Corona, California 92879 • Telephone (951) 735-6060 • Fax (951) 735-4510
28078 Baxter Road, Suite 330 • Murrieta, California 92563 • Telephone (951) 677-2157 • www.CTOAMG.com