



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for: Copies of Medical Record Paper Electronic-Portal Only

Patient Information	Patient Name: _____ MRN: _____	
	(Last Name)	(First Name)
	Date of Birth: _____	Phone: _____
	Address: _____	
	City: _____	State: _____ Zip: _____
Release To Request From	I authorize Corona Temecula Orthopaedic Associates to Release / Request Medical Records Release To: <input type="checkbox"/> Request From: <input type="checkbox"/> Person / Organization: _____	
	Address: _____	
	City / State / Zip: _____	
	Phone: _____	Fax: _____

	Purpose	For the following: <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other: _____ _____
Information to Release	Treatment Dates: _____ <input type="checkbox"/> History and Physical Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> Operative Report <input type="checkbox"/> Billing Record <input type="checkbox"/> Laboratory Report <input type="checkbox"/> EKG/ECHO <input type="checkbox"/> Pathology Report <input type="checkbox"/> Radiology Report <input type="checkbox"/> Consultation Report <input type="checkbox"/> Xray Film / Images CD <input type="checkbox"/> Other (Please Specify) _____ <input type="checkbox"/> Outpatient/ Clinic Record - Clinic / Provider Name: _____	
	State / Federal Laws require specific authorization to release the following types of information: <input type="checkbox"/> Mental Health <input type="checkbox"/> HIV test results <input type="checkbox"/> Alcohol / Drug Abuse A separate authorization is required for psychotherapy notes.	
	Fees	Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.

	MRN: _____
Delivery Instructions	<input type="checkbox"/> Mail records directly to person or organization specified <input type="checkbox"/> Call Requestor when records are ready for pick up I authorize _____ to pick up my medical record copies. Relationship to patient: _____ <input type="checkbox"/> Follow My Health (Patient Portal)
Notice of Rights	I understand that: <ol style="list-style-type: none"> If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to Corona Temecula Orthopaedics Associates 341 Magnolia Ave., Suite 101, Corona, CA 92879 If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified:
Signature	Signature: _____ Date: _____ (Patient, Power of Attorney for Healthcare or Legal Representative) Legal Representative Relationship: _____

Corona Temecula Orthopaedic Associates
341 Magnolia Ave., Suite 101, Corona, CA 92879
Phone: 951-735-6060 | Fax: 951-735-4510

Completed By: _____

Date: _____