131 Raley Blvd., Chico, CA 95928
Tele (530) 897-4500
Fax (530) 897-4544

6127 Clark Rd., Ste. 200
Tele (530) 872-1745
Fax (530) 891-6377

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I ______________________________hereby authorize and request Dr. ____________________________
(Print your name here) (Doctor you are treating with here)
to release the following information (please check all that apply):

_________ My entire OANC medical record and history of care

_________ Portion(s) of my medical record for the period of ___________ to ___________

_________ Physicians chart notes

_________ Hospital Records

_________ Copy of MRI CD

_________ My X-rays from the period of ___________ to ___________ regarding ____________________________
(List body part)

Original x-rays are the property of Orthopedic Associates and if provided, must be returned within 60 days. For return purposes, please state which doctor the films are being taken to:

Doctor: ____
Name
____
Address
____

______________________________ ______________________________
Date Signature

______________________________ ______________________________
Patient's Social Security Number Relationship to Patient

______________________________ ______________________________
Patient's Date of Birth Patient's Telephone Number

PLEASE FAX BACK TO
530-897-4544 Chico Office
530-891-6377 Paradise Office

According to California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

If you are seeking a second opinion or treatment elsewhere your feedback would be greatly appreciated. Please indicate the reason(s) why below. Orthopedic Associates of Northern California values your feedback regarding your experience with our practice. Our goals are to provide you with the most comfortable, comprehensive and efficient experience possible. To ensure patient satisfaction your comments are greatly appreciated.

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