

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION *(Print Clearly)*

Patient Name _____ DOB _____

Address (City, State, and Zip Code) _____

Phone Number _____ Email Address _____

PATIENTS PROVIDER

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Jonathan Allen, MD | <input type="checkbox"/> Paul Burton, DO | <input type="checkbox"/> Roy Caputo, MD | <input type="checkbox"/> Peter Elsisy, MD |
| <input type="checkbox"/> Wade Faerber, DO | <input type="checkbox"/> Ronny Ghazal, MD | <input type="checkbox"/> Barry Grames, MD | <input type="checkbox"/> Allen Gustafson, MD |
| <input type="checkbox"/> Zachary Hadley, MD | <input type="checkbox"/> Gail Hopkins, II, MD | <input type="checkbox"/> Asghar Husain, MD | <input type="checkbox"/> Kenneth Jahng, MD |
| <input type="checkbox"/> Anirudh Kadambi, MD | <input type="checkbox"/> Connor LaRose, MD | <input type="checkbox"/> James LaRose, DPM | <input type="checkbox"/> Sang Le, MD |
| <input type="checkbox"/> Jonathan Lee, MD | <input type="checkbox"/> James Matiko, MD | <input type="checkbox"/> Clifford Merkel, MD | <input type="checkbox"/> Anna Nikachina, MD |
| <input type="checkbox"/> Michael O'Shea, DPM | <input type="checkbox"/> Anita Pai, MD | <input type="checkbox"/> Daniel Patton, MD | <input type="checkbox"/> Bret Powers, DO |
| <input type="checkbox"/> Jay Shah, MD | <input type="checkbox"/> John Skubic, MD | <input type="checkbox"/> Jason Solomon, MD | <input type="checkbox"/> John Steinmann, DO |
| <input type="checkbox"/> Scott Stum, MD | <input type="checkbox"/> Lawrence Walker, MD | <input type="checkbox"/> Andrew Wong, MD | <input type="checkbox"/> Other: _____ |

RELEASE INFORMATION TO:

Name of Individual _____ Patient

Name of Organization / Clinic _____ Attn _____

Address (City, State, and Zip Code) _____

Phone Number _____ Fax Number* _____

**If copies exceed 25 pages, they will be mailed*

RELEASE INFORMATION TO: *(Please check all that apply):*

Specific Date/Year of Treatment _____

- Medical Records Billing Records Imaging (CD of X-Rays)

DELIVERY METHOD:

- Paper/Mail *(\$0.25 cents per printed page + plus postage)*
 Fax *(\$6.50 Flat Rate - 25 page limit)*
 Pick up *(\$0.25 cents per printed page)*
 CD of Images Only *(\$10.00 Flat Rate - Mail or Pickup)*

Medical Facility or Social Security Disability *(Free)*

PURPOSE OF RELEASE:

- Personal Use Continued Care Insurance Attorney Office
 Other _____

I understand that by signing this form, I am requesting that the health information specified be sent to the third party listed above. I understand that I may revoke this request anytime in writing to Arrowhead Orthopaedics. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law. **Please allow up to 14 days for records to be processed. Pick up hours are Monday- Friday from 8-11 am & 2-4 pm. Contact us at 909-557-1600 x1209 if you have any questions.**

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient) _____

Submit completed authorization form by:

- Email: aomedicalrecords@arrowheadortho.com
- Fax: (909) 557-1736
- In person at: **Arrowhead Orthopaedics**
Medical Records Department
1801 Orange Tree Lane, Ste 200 Redlands, CA 92374
Monday – Friday, 8-11 am and 2-4 pm

***Our Office will call or email you with the amount due when the records are ready.**