ARROWHEAD ORTHOPAEDICS
"A Tradition of Excellence"

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

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

HEALTH INFORMATION RELEASED 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*

HEALTH INFORMATION TO BE RELEASED *(Please check all that apply)*:

Specific Date/Year of Treatment _____

☐ Medical Records ☐ Billing Records ☐ Imaging

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) _____

FOR OFFICE USE ONLY: Processed By (Print) _____ **Date** _____