



Tri-Valley Orthopedic Specialists, Inc.

Solving Musculoskeletal Problems Since 1985

INFORMATION ON THE MEDICAL RECORDS RELEASE FORM:

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Suite 130
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tel 925-275-1133
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Livermore
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tel 925-373-9182
fax 925-373-2492

Tracy
632 W. 11th Street
Suite 219
Tracy, CA 95376
tel 209-833-6821
fax 209-833-3328

Business Office
5601 Norris Canyon Rd.
Suite 130
San Ramon, CA 94583
tel 925-560-9300
fax 925-560-0648

1. The request for release of medical records must be completed in full by the patient or patient's Parent or duly appointed legal guardian (for pediatric patients only). If incomplete, we will return the request.
2. Request for records that include HIV or Substance Abuse information must be specifically stated.
3. If a record is being sent to anyone other than the patient, there should be identification of the recipient (including address) and a statement of what is the authority of the recipient to receive the records. The authority statement should include relationship and purpose of the request.
4. The patient must pay in advance for copies of the record.
5. The patient must supply name at time of service, birth date, Social Security Number and approximate year seen to assist in locating the record.
6. We accept fax request for all Medical Records.
7. We do not provide information on whether a person is a patient or not without a formal Medical Records Release request or subpoena. All subpoenas are to be received by the Custodian of Records.
8. We **do not** expedite requests.
9. We **do not** release original films.
10. We ask that you be as detailed as possible on your request.
11. If you have any questions or need assistance in completing this form, please contact the Medical Records Liaison at (925) 560-9300.

By signing this Authorization, you acknowledge that this authorization will expire within 30 days from the date of the signature on the authorization. Furthermore, your signature on this Authorization acknowledges that you have read and understand the terms of this Authorization and that you have had the opportunity to ask questions about the use disclosure of your health information.

****PLEASE RETAIN THIS PAGE FOR YOUR RECORDS****



Tri-Valley Orthopedic Specialists, Inc.

5601 Norris Canyon Road, #130, San Ramon, CA 94583
Tel: (925) 463-6255 ext. 155 Fax: (925) 275-1298

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PRINT PATIENT LAST NAME	FIRST NAME	BIRTH DATE	
ADDRESS	CITY	STATE	ZIP CODE
OTHER NAME PATIENT RECEIVED TREATMENT UNDER	PHONE NUMBER	FAX NUMBER	
SOCIAL SECURITY NUMBER	ACCOUNT NUMBER		

SEND MY RECORDS TO THE FOLLOWING:

NAME OF PHYSICIAN/HEALTHCARE PROVIDER/OTHER
ADDRESS
CITY/STATED/ZIP CODE
PHONE NUMBER

The complete medical records in your possession concerning my illness and/or treatment from _____ DATE to _____ DATE.

INFORMATION TO BE RELEASED IS LIMITED TO THE FOLLOWING:

<input type="checkbox"/> BILLING RECORDS	<input type="checkbox"/> X-RAY FILMS
<input type="checkbox"/> OPERATIVE REPORTS	<input type="checkbox"/> MRI FILMS
<input type="checkbox"/> BONE DENSITY TEST RESULTS	<input type="checkbox"/> LAB RESULTS
<input type="checkbox"/> MRI REPORTS	<input type="checkbox"/> OTHER
DATE(S) OF ABOVE INFORMATION TO BE SENT:	

NOTE: Tri-Valley Orthopedic will provide a copy of your Medical Records at a fee of \$15.00 to you within **5-7 business days** after the date of your request. Payment may be made with cash, credit card or personal check payable to **Tri-Valley Orthopedic Specialists, Inc.**, due with your request. Copies of x-rays and MRIs are **\$15.00 per CD**.

DATE

PATIENT SIGNATURE

PARENT, LEGAL GUARDIAN OR REPRESENTATIVE