ORTHOPEDIC ASSOCIATES of Northern California
131 Raley Blvd Chico, CA 95928
Tele (530) 897-4500
Fax (530) 897-4544

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 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

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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