COMMUNITY ORTHOPEDIC MEDICAL GROUP

Orthopedic Specialists

26401 Crown Valley Parkway, Suite 101 ♦ Mission Viejo, CA 92691

Tel: (949) 348-4000 ♦ Fax (949)348-0136 ♦ Web: www.comg.com

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Date:_____ Medical Record#:_____ (For office use)

Patient Name (Please print):_____ ,_____
Last Name First Name

Address:_____

Date of Birth:_____ Telephone Number:_____

AUTHORIZATION:
I hereby authorize **COMMUNITY ORTHOPEDIC MEDICAL GROUP** to release a copy of my health information to the person/organization specified below:

❑ Mail to the address listed below ❑ Email:_____
Print

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

Release information regarding:

❑ All Medical Records
❑ Progress Notes
❑ Lab Test Reports
❑ Physical Therapy Reports
❑ Surgery Reports
❑ Other (Specify):_____

❑ Radiology Reports (MRI, CT Scan, X-ray, Dexa Scan, EMG)
❑ Radiology Film/CDs (X-ray, CT, MRI)
***CD is not compatible & cannot be opened by MAC computers**

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Patient Name (Please print):_____ ,_____
Last Name First Name

**The medical information/records will be used for the following purpose:

_____

**If moving, please provide new mailing address:

_____

_____

This authorization is:

[☐] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment

[☐] Limited to the following medical information:_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial) HIV Diagnosis/Treatment _____(initial)
Psychiatric/Mental Health _____(initial) Genetic Information _____(initial)
Tests for Antibodies to HIV _____(initial)

DURATION:

This authorization shall be effective immediately and remain in effect until _____
DATE

RESTRICTIONS:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name and Relationship to Patient

Fees: Records: $15.00 CD: $5.00 Records & CD: $20.00 *Please allow 48 hours for processing

Check should be made out to: Community Orthopedic Medical Group
26401 Crown Valley Pkwy. #101, Mission Viejo, CA 92691

OFFICE USE ONLY

PAYMENT OF $_____ Collected by:_____ Date received_____

NOTES : _____

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