Tri-Valley Orthopedic Specialists, Inc.
Solving Musculoskeletal Problems Since 1985

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Suite 100
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Medical Office
tel 866-623-7600
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Business Office
tel 925-469-0939
fax 925-469-0165

INFORMATION ON THE MEDICAL RECORDS RELEASE FORM:

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) 463-0470 ext. 155.

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 disclosure of your health information.

PRINT FORM AND BRING TO OFFICE OR MAIL

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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	

MAIL MY RECORDS TO THE FOLLOWING

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

or PICK UP AT	☐ Pleasanton Office	☐ San Ramon Office	☐ Tracy Office

☐ 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:

☐ BILLING RECORDS	☐ X-RAY FILMS
☐ OPERATIVE REPORTS	☐ MRI FILMS
☐ BONE DENSITY TEST RESULTS	☐ LAB RESULTS
☐ MRI REPORTS	☐ OTHER
DATE(S) OF ABOVE INFORMATION TO BE SENT:	

NOTE: Tri-Valley Orthopedics will provide a copy of your Medical Records at a fee of $25.00 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

Incorporated by the State of California as Tri-Valley Orthopedics and Sports Medical Group, Inc. / dba Tri-Valley Orthopedic Specialists, Inc.