Tri-Valley Orthopedic Specialists, Inc.
SOLVING MUSCULOSKELETAL PROBLEMS SINCE 1985

4626 Willow Rd. Pleasanton, CA 94588 Fax: 925-463-0473
5601 Norris Canyon Rd. #130 San Ramon, CA 94583
2180 West Grant Line Rd. Tracy, CA 95376

MRN# _____

As per CA law (AB610), this request will be processed within 15 business days from the time it is received. Your authorization and payment must be completely filled out in order to process your request. All payments are to be made in advance by providing debit or credit card information on the attached payment form.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:			
Last Name:	First Name:	Date of Birth:	E-mail Address:
Address:	City:	State:	Zip:

SEND MEDICAL RECORDS AND/OR RADIOLOGY IMAGES TO:			
☐ Same as above ☐ Healthcare Provider ☐ Other			
Name or Healthcare Providers Info:			Phone:
Address:	City:	State:	Zip:

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

Drug/Alcohol/Substance Abuse _____ (initial) Psychiatric/Mental Health _____ (initial)

Tests for Antibodies to HIV _____ (initial) HIV Diagnosis _____ (initial) Genetic Information ____ (initial)

How do you want to receive your Medical Records? **All Radiology Images Will be put on a CD**

☐ **Mailed** or ☐ **Pick Up @ Pleasanton office** ☐ **CD**

AUTHORIZATION TO RELEASE: Check the appropriate boxes, provide specific information as needed.

☐ **All Medical Records**	☐ **Specific Dates of Service:**
☐ **Other**	☐ **Operative Reports**
	☐ **X-Ray and or MRI Images**

Patient/Representative Signature: _____ **Date**_____

*** If signed by anyone other than the patient, please indicate your legal relationship in order for us to accept this request.** _____

If you haven't received your Medical Records/ Radiology Images within 15 business days, please contact Tri Valley Orthopedic Specialist @ (925) 463-0470. www.trivalleyorthopedics.com

PATIENT PAY PROGRAM

Patient Name: _____ Daytime contact #: _____

Medical Records Requests: A standard $25.00 fee for 1-50 pages. 51+ pages will be $0.25 cents per page

Radiology Image Requests (X-Ray/ MRI): A standard $6.50 fee

Payment Information (To Be Completed by Patient)

☐ Credit/ Debit Card (MC, Visa, AMEX)

Credit/Debit Card Number: _____

Expiration Date: _____ 3 Digit Security Code: _____

Name on Credit Card: _____

Signature of credit card holder: _____

Billing Address: _____