

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

## PATIENT INFORMATION *(Print Clearly)*

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Address (City, State, and Zip Code) \_\_\_\_\_

Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_

## PATIENTS PROVIDER

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Jonathan Allen, MD  | <input type="checkbox"/> Paul Burton, DO      | <input type="checkbox"/> Roy Caputo, MD      | <input type="checkbox"/> Peter Elsisy, MD    |
| <input type="checkbox"/> Wade Faerber, DO    | <input type="checkbox"/> Ronny Ghazal, MD     | <input type="checkbox"/> Barry Grames, MD    | <input type="checkbox"/> Allen Gustafson, MD |
| <input type="checkbox"/> Zachary Hadley, MD  | <input type="checkbox"/> Gail Hopkins, II, MD | <input type="checkbox"/> Asghar Husain, MD   | <input type="checkbox"/> Kenneth Jahng, MD   |
| <input type="checkbox"/> Anirudh Kadambi, MD | <input type="checkbox"/> Connor LaRose, MD    | <input type="checkbox"/> James LaRose, DPM   | <input type="checkbox"/> Sang Le, MD         |
| <input type="checkbox"/> Jonathan Lee, MD    | <input type="checkbox"/> James Matiko, MD     | <input type="checkbox"/> Clifford Merkel, MD | <input type="checkbox"/> Anna Nikachina, MD  |
| <input type="checkbox"/> Michael O'Shea, DPM | <input type="checkbox"/> Anita Pai, MD        | <input type="checkbox"/> Daniel Patton, MD   | <input type="checkbox"/> Bret Powers, DO     |
| <input type="checkbox"/> Jay Shah, MD        | <input type="checkbox"/> John Skubic, MD      | <input type="checkbox"/> Jason Solomon, MD   | <input type="checkbox"/> John Steinmann, DO  |
| <input type="checkbox"/> Scott Stum, MD      | <input type="checkbox"/> Lawrence Walker, MD  | <input type="checkbox"/> Andrew Wong, MD     | <input type="checkbox"/> Other: _____        |

## RELEASE INFORMATION TO:

Name of Individual \_\_\_\_\_  Patient

Name of Organization / Clinic \_\_\_\_\_ Attn \_\_\_\_\_

Address (City, State, and Zip Code) \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number\* \_\_\_\_\_

*\*If copies exceed 25 pages, they will be mailed*

## RELEASE INFORMATION TO: *(Please check all that apply):*

Specific Date/Year of Treatment \_\_\_\_\_

- Medical Records     Billing Records     Imaging (CD of X-Rays)

## DELIVERY METHOD:

- Paper/Mail *(\$0.25 cents per printed page + plus postage)*  
 Fax *(\$6.50 Flat Rate - 25 page limit)*  
 Pick up *(\$0.25 cents per printed page)*  
 CD of Images Only *(\$10.00 Flat Rate - Mail or Pickup)*

### Medical Facility or Social Security Disability *(Free)*

## PURPOSE OF RELEASE:

- Personal Use     Continued Care     Insurance     Attorney Office  
 Other \_\_\_\_\_

I understand that by signing this form, I am requesting that the health information specified be sent to the third party listed above. I understand that I may revoke this request anytime in writing to Arrowhead Orthopaedics. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law. **Please allow up to 14 days for records to be processed. Pick up hours are Monday- Friday from 8am - 4 pm. Contact us at 909-557-1600 x1209 if you have any questions.**

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if requester is not the patient) \_\_\_\_\_

## Submit completed authorization form by:

- Email: [aomedicalrecords@arrowheadortho.com](mailto:aomedicalrecords@arrowheadortho.com)
- Fax: (909) 557-1736
- In person at: **Arrowhead Orthopaedics**  
**Medical Records Department**  
**1801 Orange Tree Lane, Ste 200 Redlands, CA 92374**  
**Monday – Friday, 8am - 4pm**

**\*Our Office will call or email you with the amount due when the records are ready.**