



**SOUTH ORANGE  
COUNTY ORTHOPAEDICS, INC.**

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**Authorization Form For Use or Disclosure of Protected Health Information:  
Medical Records**

I hereby authorize South Orange County Orthopaedic Inc. (“Provider”) to disclose to all of the information contained in my Medical Record(s). I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of Protected Health Information (PHI) and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this Protected Health Information.

*The specific Protected Health Information (Medical Records) that will be disclosed is:*

**\*Patient Name:** \_\_\_\_\_

**\*Date of Birth:** \_\_\_\_\_

**\*Patient’s Doctor:** **Fitzpatrick Park Eidt Elzik Wang**

**\*Date(s) Records Request From:** \_\_\_\_\_ **To:** \_\_\_\_\_

*Medical facility/person you would like to receive the medical records:*

**\*Name:** \_\_\_\_\_

**\*Address:** \_\_\_\_\_ **City, State, Zip:** \_\_\_\_\_

**\*Telephone Number:** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is released. I understand that the Provider will produce this information within 15 business days from receipt of request, and I may be subject to a reasonable clerical cost for preparing and furnishing this information. California Evidence Code Section 1560-1567, Evidence Code Section 1158, Health & Safety Code Section 123100.

**\*Patient/Representative Signature:** \_\_\_\_\_

**\*Patient/Representative Printed Name:** \_\_\_\_\_

**Medical Records Copying Fee:** Copying and sending medical records: **\$20.00**  
Copying of X-Rays films: **\$15.00**

**Note:** There is no charge for sending medical records to another medical facility.  
Please make checks payable to: **South Orange County Orthopaedics Inc.**