ALTA
ORTHOPAEDICS

REQUEST FOR RELEASE OF MEDICAL RECORDS TO ALTA ORTHOPAEDICS

Date of request:	Patient's Name:	
Date of Birth:	Patient's phone #:	Last 4 of SS#:
Patient's Address:		

I, the undersigned, authorize the following doctor's office to release my medical and/or billing information to Alta Orthopaedics:

Name of practice or Doctor: _____ Phone #: _____

Address: _____

Please see below for records being requested.

Delivery Method

❍ Mail - Address: ❍ Santa Barbara - 511 Bath Street, Santa Barbara, CA ❍ Solvang - 2027 Village Lane, Suite 101, Solvang, CA

❍ Fax - Number: (805) 962-2154

❍ Email (patient only):

❍ I will pick up at your office. Please call me when ready for pick up.

Information to be Released

Covering the periods of Health Care from (date) ____ / ____ / ____ to (date) ____ / ____ / ____

❍ X-rays Please specify: ❍ I need all x-rays *or* ❍ only:

❍ Medical records: ❍ Work Comp (Injury date:) ❍ Private *or* ❍ ALL

❍ Billing records: ❍ Work Comp (Injury date:) ❍ Private *or* ❍ ALL

Drug and/or Alcohol Abuse, Psychiatric, Psychological Care, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information, I agree to its release.

Re-Disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided soley to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I am advised to request a copy of this signed release form for my records. I authorize the Center to use and disclose the protected health information specified above.

Signature _____ Date ____ / ____ / ____

Printed Name _____

If not the patient, please indicate your relationship to the patient: _____

Santa Barbara
511 Bath Street
Santa Barbara, CA 93101
(805) 963-9377

Solvang
2027 Village Lane, Suite 101
Solvang, CA 93463
(805) 688-8821

www.altaortho.com

FOR OFFICE USE ONLY: Date completed_____ By_____