

## South Orange County Orthopaedics

Michael J. Fitzpatrick, M.D. Kenneth J. Wilkens, M.D.

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### Authorization form for use or disclosure of medical records:

I, \_\_\_\_\_ hereby authorize South Orange County Orthopaedics to  
release my records to:

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

\* Address: \_\_\_\_\_

\* Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

\* Patient's Doctor:    **Fitzpatrick**        **Sohn**        **Wilkens**        **Eidt**        **Ishimaru**  
(Circle One)

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

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

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

### Medical Records Fee: \$20.00

Unless sending directly to another doctors office.

Make checks payable to: South Orange County

Orthopaedics

We only accept Visa, MC, & Discover

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.

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.