Jason S. Bell, M.D.
Shaun M. Hobson, M.D.
Wesley J. Johnson, M.D.

Ryan D. Pederson, D.P.M.
Garry T. Vallier, M.D.

South Coast Orthopaedic Associates, P.C.

Pt. I.D. # _____

2699 N. 17TH STREET | COOS BAY, OREGON 97420 | (541) 266-3600 | 1-800-930-7668 | www.scoastortho.com

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

No records will be released unless the authorization form is complete, dated and signed by the patient or by a person authorized by law to give this authorization.

☐ **I authorize South Coast Orthopaedic Associates to release a copy of the medical information for:**

☐ **I authorize** _____
NAME OF PROVIDER ADDRESS CITY STATE ZIP PHONE NUMBER

to release a copy of the medical information for:

_____ / _____ / _____
NAME OF PATIENT DATE OF BIRTH SOCIAL SECURITY NUMBER

_____
OTHER PREVIOUS NAMES (MAIDEN, MARRIED, ETC.)

Choose only <u>one</u> of the two below:

1. This authorization is limited to the following treatment (name body part) _____
_____
2. This authorization is limited to the following time period (please be specific) _____
_____

Mail the records to the following address: **Fax:** _____
_____
_____
_____

<u>INITIALING</u> the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ Clinician Office Chart Notes
_____ Laboratory Reports
_____ Operative Reports
_____ Diagnosic Imaging **Reports** (X-Ray, MRI)
_____ Diagnosic Imaging **Discs** (X-Ray, MRI)
_____ Pathology Reports
_____ Other _____
_____ HIV/AIDS Related Records *(Must be initialed to be included in other documents.)* **Validity Date** _____
_____ Mental Health Information *(Must be initialed to be included in other documents.)* **Validity Date** _____
_____ Genetic Testing Information *(Must be initialed to be included in other documents.)* **Validity Date** _____
_____ Drug/Alcohol Diagnosis, Treatment or Referral Information *(Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.)*
Validity Date _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire **180** days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
DATE SIGNED SIGNATURE OF PATIENT OR PERSON AUTHORIZIED BY LAW

_____
DATE SENT