



# Tri-Valley Orthopedic Specialists, Inc.

SOLVING MUSCULOSKELETAL PROBLEMS SINCE 1985

4626 Willow Rd. Pleasanton, CA 94588 Fax: 925-463-0473  
5601 Norris Canyon Rd. #130 San Ramon, CA 94583  
2180 West Grant Line Rd. Tracy, CA 95376

MRN#

As per CA law (AB610), this request will be processed within 15 business days from the time it is received. Your authorization and payment must be completely filled out in order to process your request. All payments are to be made in advance by providing debit or credit card information on the attached payment form.

## AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

<b>PATIENT INFORMATION:</b>			
Last Name:	First Name:	Date of Birth:	E-mail Address:
Address:	City:	State:	Zip:
<b>SEND MEDICAL RECORDS AND/OR RADIOLOGY IMAGES TO:</b>			
<input type="checkbox"/> Same as above <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Other			
Name or Healthcare Providers Info:			Phone:
Address:	City:	State:	Zip:

### I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse \_\_\_\_ (initial)      Psychiatric/Mental Health \_\_\_\_ (initial)  
Tests for Antibodies to HIV \_\_\_\_ (initial)    HIV Diagnosis \_\_\_\_ (initial)    Genetic Information \_\_\_\_ (initial)

### How do you want to receive your Medical Records?

### All Radiology Images Will be put on a CD

Mailed    or     Pick Up @ Pleasanton office       CD

## AUTHORIZATION TO RELEASE: Check the appropriate boxes, provide specific information as needed.

<input type="checkbox"/> All Medical Records	<input type="checkbox"/> Specific Dates of Service:
<input type="checkbox"/> Other	<input type="checkbox"/> Operative Reports
	<input type="checkbox"/> X-Ray and or MRI Images

Patient/Representative Signature: \_\_\_\_\_ Date \_\_\_\_\_

\* If signed by anyone other than the patient, please indicate your legal relationship in order for us to accept this request. \_\_\_\_\_

If you haven't received your Medical Records/ Radiology Images within 15 business days, please contact Tri Valley Orthopedic Specialist @ (925) 463-0470. [www.trivalleyorthopedics.com](http://www.trivalleyorthopedics.com)

# PATIENT PAY PROGRAM

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

Daytime contact #: \_\_\_\_\_

**Medical Records Requests:** A standard \$25.00 fee for 1-50 pages. 51+ pages will be \$0.25 cents per page

**Radiology Image Requests (X-Ray/ MRI):** A standard \$6.50 fee

## Payment Information (To Be Completed by Patient)

Credit/ Debit Card (MC, Visa, AMEX)

Credit/Debit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ 3 Digit Security Code: \_\_\_\_\_

Name on Credit Card: \_\_\_\_\_

Signature of credit card holder: \_\_\_\_\_

Billing Address: \_\_\_\_\_