SAN DIEGO ORTHOPAEDIC ASSOCIATES
MEDICAL GROUP, INC.
PHYSICIANS AND SURGEONS

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WILLIAM C. McDADE, M.D.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________ **Date:** __________

Former Name(s), if any: ________________________ **DOB:** __________

The records designated below should be mailed* to (provide address): ________________

____

*Please note that SDOAMG's weekly copy day is Wednesday. Patient records will be mailed via U.S. Mail 3-5 business days following the next copy day.

This Authorization will allow San Diego Orthopaedic Associates Medical Group, Inc. (SDOAMG) to furnish the above-named party with my medical record information designated below. I understand that this Authorization will remain in effect for a period of 12 months unless I revoke it in writing at any time, according to the instructions in the Notice of Privacy Practices, except to the extent that action has already been taken in reliance on this Authorization.

I acknowledge that once my patient information leaves the premises, SDOAMG will no longer be able to protect the information, and recipients of the information may not be required to protect it.

I understand that SDOAMG cannot condition services on whether or not the patient signs the authorization, except under limited circumstances, such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as Workers' Compensation).

Information to be Sent:

______ Clinic Notes
______ Lab
______ EKGs
______ HIV/AIDS testing
______ Mental health reports
______ Drug & alcohol treatment
______ Records from the specific time period from __________ to __________

______ Doctor's orders
______ Treatment Notes
______ X-rays (please note if actual films are needed)
______ Other diagnostic tests
Specify: ______________________________

Signed: ______________________________ Printed Name: ____________________

Date: ______________________________