

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

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*ESTABLISHED 1947*

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WILLIAM C. McDADE, M.D.

INTERVENTIONAL PAIN MANAGEMENT

KEVIN T. TOLIVER, M.D.

**AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Former Name(s), if any:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Purpose of Release:** \_\_\_\_\_

**I Authorize** \_\_\_\_\_

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

**To Disclose To:** San Diego Orthopaedic Associates Medical Group Inc.  
4060 Fourth Avenue, Suite 700  
San Diego, CA 92103

\*This authorization will allow you to furnish the above-named party with my medical record information, without limitation, regarding my physical and mental condition, as revealed by your observation and/or treatment, past, present, or future. This authorization shall remain in effect for one year from the date specified above.

**Information to be Sent:**

_____ Clinic Notes	_____ Doctor's orders
_____ Lab	_____ Treatment Notes
_____ EKGs	_____ X-rays (please note if actual films are needed)
_____ HIV/AIDS testing	_____ Other diagnostic tests
_____ Mental health reports	Specify: _____
_____ Drug & alcohol treatment	
_____ Records from the specific time period from _____ to _____	

**Signed:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_