ARROWHEAD ORTHOPAEDICS
"A Tradition of Excellence"

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION *(Print Clearly)*

Patient Name _____ DOB _____

Address (City, State, and Zip Code) _____

Phone Number _____ Email Address _____

PATIENTS PROVIDER

- ☐ Jonathan Allen, MD
- ☐ Wade Faerber, DO
- ☐ Zachary Hadley, MD
- ☐ Anirudh Kadambi, MD
- ☐ Jonathan Lee, MD
- ☐ Michael O'Shea, DPM
- ☐ Jay Shah, MD
- ☐ Scott Stum, MD
- ☐ Paul Burton, DO
- ☐ Ronny Ghazal, MD
- ☐ Gail Hopkins, II, MD
- ☐ Connor LaRose, MD
- ☐ James Matiko, MD
- ☐ Anita Pai, MD
- ☐ John Skubic, MD
- ☐ Lawrence Walker, MD
- ☐ Roy Caputo, MD
- ☐ Barry Grames, MD
- ☐ Asghar Husain, MD
- ☐ James LaRose, DPM
- ☐ Clifford Merkel, MD
- ☐ Daniel Patton, MD
- ☐ Jason Solomon, MD
- ☐ Andrew Wong, MD
- ☐ Peter Elsissy, MD
- ☐ Allen Gustafson, MD
- ☐ Kenneth Jahng, MD
- ☐ Sang Le, MD
- ☐ Anna Nikachina, MD
- ☐ Bret Powers, DO
- ☐ John Steinmann, DO
- ☐ Other: _____

HEALTH INFORMATION RELEASED TO:

Name of Individual _____ ☐ Patient

Name of Organization / Clinic _____ Attn _____

Address (City, State, and Zip Code) _____

Phone Number _____ Fax Number* _____

**If copies exceed 25 pages, they will be mailed*

HEALTH INFORMATION TO BE RELEASED *(Please check all that apply)*:

Specific Date/Year of Treatment _____

☐ Medical Records ☐ Billing Records ☐ Imaging

DELIVERY METHOD:

- ☐ Paper/Mail *($0.25 cents per printed page + plus postage)*
- ☐ Fax *($6.50 Flat Rate - 25 page limit)*
- ☐ Pick up *($0.25 cents per printed page)*
- ☐ CD of Images Only *($10.00 Flat Rate - Mail or Pickup)*
- **Medical Facility or Social Security Disability *(Free)***

PURPOSE OF RELEASE: ☐ Personal Use ☐ Continued Care ☐ Insurance ☐ Attorney Office
☐ Other _____

I understand that by signing this form, I am requesting that the health information specified be sent to the third party listed above. I understand that I may revoke this request anytime in writing to Arrowhead Orthopaedics. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law. **Please allow up to 14 days for records to be processed. Pick up hours are Monday- Friday from 8-11 am & 2-4 pm. Contact us at 909-557-1600 x690 if you have any questions.**

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient) _____

FOR OFFICE USE ONLY: Processed By (Print) _____ **Date** _____