Bay Area Orthopedic Surgery and Sports Medicine
100 Hospital Dr. Suite 303
Vallejo, CA 94589
Phone 707-645-7210 Fax 707-645-7249
www.baosurgery.com
administrator@baosurgery.com

Outgoing Authorization for Release of Information

PATIENT NAME___________________________________
LAST,FIRST

DATE OF BIRTH:_______________ SS#: ________________

ADDRESS: _____________________________________
____

DAY PHONE: __________________ALTERNATE PHONE:______________

I hereby authorize Bay Area Orthopedics, to release information from my medical record as indicated below to:

NAME: ____

ADDRESS:____

CITY:____________________ STATE: _____ ZIP: __________

PHONE: ____________________ FAX: _________________________

INFORMATION TO BE RELEASED: DATES:

History and physical exam ________________ TO _____________
Progress notes ________________ TO ______________
Lab reports ________________ TO ______________
X-ray reports ________________ TO ______________
Other: ________________ ________________ TO ______________

I specifically authorize the release of information relating to:

_ Substance abuse (including alcohol/drug abuse)
_ Mental health (including psychotherapy notes)
_ HIV related information (AIDS related testing)

X______________________________________ ________________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE:
_Changing physicians _ Consultation/second opinion _ Continuing care
_ Legal _ School _ Insurance _ Workers Compensation
_ Other (please specify):
____

1. I understand that this authorization will expire 90 days after I have signed the form.

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2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that if I am being requested to release this information by my physician for the purpose of: ________________________
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.

5. I understand that pursuant to CA, Health & Safety Code section 123110, a doctor can charge 25 cents per page plus a reasonable clerical fee. I understand that I will pay a fee for these records.
   Records are copied by __________________________ and their fee schedule is listed below:
   - $25.00 for up to 100 pages - .25 per page after first 100 pages
   - No charge for delivery if picked up at the office - charged their cost if records need to be mailed.
     Checks can be mailed payable to Teodoro P. Nissen M.D., INC.

_____________________________________ ______________
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN/ DATE
AUTHORIZED PERSON

____
RELATIONSHIP TO PATIENT

For Office Use Only

Date Request Filled: ____________________ By: ______________________

Records were: _Mailed_ Faxed _Hand Delivered Identification Presented

Initial Fee $25.00Pages ___ X .25 each(if over 100 pages) Postage $__________

Total Money Collected $____________