

**San Diego Sports Medicine & Orthopaedic Center**

6719 Alvarado Road, Suite 200 ♦ San Diego, CA 92120-5256 ♦ Tel (619) 229-3932  
Fax (619) 582-2860 ♦ www.sdsdm.net

James P. Tasto, MD ♦ Rina Jain, MD, FRCSC ♦ Jonathan J. Myer, MD, Bryan T. Leek, MD

**Authorization to Receive or Release Medical Information**

*Please read carefully*

**Explanation:** This form authorizes the disclosure and/or use of protected health information as described below and is voluntary.

**Duration:** I understand this authorization may be revoked by me at any time in writing. Unless otherwise revoked, this authorization is valid for one year.

**Restrictions:** I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. Please note that if you authorize disclosure of your private health information to someone who is not legally bound to keep it confidential, it may no longer be protected. I hereby release SDSM from any and all legal liability that may arise from the release of information to the party I have named above.

**Additional Copy:** I understand that I have a right to receive a copy of this authorization upon my request.

**Use of Information:** This information supplied is to be used for the following purpose(s):

Continuing Care    Insurance    Personal    Attorney    Other \_\_\_\_\_   Patient Initials \_\_\_\_\_

**Authorization:** I authorize the release of information pertaining to my medical history, mental, or physical condition, services rendered, or treatment, as described below:

Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_

Telephone# (\_\_\_\_\_) \_\_\_\_\_

**Record Holder: San Diego Sports Medicine & Orthopaedic Center 6719 Alvarado Rd., #200 San Diego, CA 92120**

**Records May Be Released To:** \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**Type of Information:** I understand that I have the right to limit the type of information to be released. I have indicated below the information which is authorized for release:

- All medical information, without exception, including information regarding AIDS and AIDS testing, psychological or psychiatric treatment and drug or alcohol abuse. This includes doctor’s notes, labs, operative reports, consultation reports, history and physical examination, progress notes, discharge summary, x-ray and other diagnostic tests.
- All medical information **except** the following: \_\_\_\_\_
- X-rays / MRI / CT / Bone Scan / Other: \_\_\_\_\_ (Circle One) I understand that x-rays taken at SDSM must be returned within 30 days unless otherwise arranged and it is my responsibility to return them to SDSM. \_\_\_\_\_ (Patient Initials)
- Only the following information: \_\_\_\_\_

**Legal Signature:**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

