Orthopaedic Medical Group of Riverside, Inc.

RIVERSIDE OFFICE
6800 Brockton Avenue
Riverside, CA 92506
Phone: (951) 683-0650
Fax: (951) 683-0988

MORENO VALLEY OFFICE
6485 Day Street
Suite 301
Riverside, CA 92507
Phone: (951) 653-0760
Fax: (951) 653-9820

SAN BERNARDINO OFFICE
399 E. Highland Avenue
Suite 409
San Bernardino, CA 92404
Phone: (951) 683-0650
Fax: (951) 683-0988

LAKE ARROWHEAD OFFICE
29099 Hospital Road
Suite 112
Lake Arrowhead, CA 92352
Phone: (951) 337-9300
Fax: (951) 337-6440

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR PURPOSES REQUESTED OF PHYSICIAN'S OFFICE

I, (*Print Name*) _____, hereby authorize Orthopaedic Medical Group of Riverside, Inc to: (check those that apply)

- ❑ Use the following protected health information for OMG to provide medical services to me, and/or
- ❑ Disclose the following protected health information to:
- ❑ Provide to me X-ray films that I will hand carry to:

_____

(Name of entity to receive information from OMG ❑ or send information to OMG ❑) (Please Print)

_____

(Street Address)

_____

(City) *(State)* *(Zip Code)*

I authorize the following protected health information to be used and/or disclosed:

❑	All medical records	❑	All dates of Service	❑	Specific Dates of Service:	_____
❑	Office Notes	❑	All dates of Service	❑	Specific Dates of Service:	_____
❑	Operative Reports	❑	All dates of Service	❑	Specific Dates of Service:	_____
❑	X-rays	❑	All dates of Service	❑	Specific Dates of Service:	_____
❑	Laboratory	❑	All dates of Service	❑	Specific Dates of Service:	_____
❑	Billing Records	❑	All dates of Service	❑	Specific Dates of Service:	_____
❑	Other	Specify:	_____			
❑	Other	Specify:	_____			

This protected health information is being used or disclosed for the following purposes: *(List specific purposes here)*

_____

_____

This authorization shall be in force and effect until:

- ❑ One (1) year from the date of signing this form
- ❑ Other (specify a date or an event) _____

At which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the OMG Medical Records Supervisor at 6800 Brockton Avenue, Riverside, CA 92506. I understand that a revocation is not effective to the extent that OMG has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

OMG will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights),
- Refuse to sign this authorization.

_____ _____ _____

Name of Patient (Print) *Signature of Patient or Personal Representative* *Date*

_____

Description of Personal Representative's Authority (i.e. parent, legal guardian, power of attorney)

_____ _____ _____

Patient's Date of Birth *Patient's Social Security #* *Patient's Daytime phone #*