

MEDICAL RECORDS/IMAGES RELEASE FORM

☐ CD of X-Rays, MRI, Ultrasound \$15 (each)

** Processing Time is 7-10 Business Days ** Processing Time is 3 Business Days Copying fees are: \$20.00 for chart records and/or \$15.00 for an Imaging CD. Fees must be paid for MOS to process this request. No Records will be copied if fees are not paid. This document authorizes Dr. of Muir Orthopaedic Specialists to release the records of: Physician's Name (s) **Last 4 of S. S. #** Date of Birth **Patient Name Daytime Phone Number** Fax Number MOS Images needed: Body Part(s): Approximate Dates Images taken on: _ Initial PLEASE NOTE: ONLY IMAGES TAKEN AT MUIR ORTHOPAEDICS WILL BE COPIED ONTO YOUR CD. FOR IMAGES TAKEN ELSEWHERE, CONTACT THE FACILITY WHERE THEY WERE TAKEN. I agree that any and all medical information may be released, including but not limited to mental health, drug and alcohol use, HIV/AIDS test results, and any other records protected by State or Federal laws. Initial I request that release of medical information be restricted to the following portion of my medical records: Initial **DELIVERY INSTRUCTIONS FOR RECORDS/CD:** ☐ Picking up myself (**photo ID will be required**) ☐ Mailed ☐ Faxed (Chart records only) Pick Up Location: ☐ Sequoia Office ☐ Redwood Office ☐ San Ramon Office ☐ Brentwood Office ☐ Concord Office Mail To: Name of Physician/Diagnostic test facility/Self/Other Street Address Zip City State **Daytime Phone Number** This consent will expire 90 days after date of signature and is not valid without signature of patient/authorized representative: **SIGNATURE:** Patient/Guardian/Personal Representative Signature Patient/Guardian/Personal Representative Name (Print) Date THIS FORM MAY BE DROPPED OFF AT ANY OF OUR LOCATIONS, FAXED (VIA SECURE FAX) WITH A SIGNED CREDIT CARD AUTHORIZATION FORM, OR MAILED WITH PAYMENT (CHECKS ONLY) TO: MUIR ORTHOPAEDIC SPECIALISTS, ATTN: MEDICAL RECORDS, 2405 SHADELANDS DRIVE, WALNUT CREEK, CA 94598 TELEPHONE: 925-939-8585 SECURE FAX: 925-933-4932 FEE PAID: AMT \$ _____ DATE: ____ INIT: ____ FOR OFFICE USE ONLY: Rcvd by Med Records: Date _____ Init ____ Pt Called (P/u only): Date_____ Init ____ Picked-up (ID Verified): Date ____ Rcvd by Film Library: Date ____ Init ____ Mailed/Faxed: Date____ Init ____ Init ____ Patient Signature (Pickup only): _____ Date: _____

☐ Chart Records (Copy) \$20