Name:
DOB:
Chart:
Age:
Date:

RECORDS RELEASE

Pasadena Orthopedics has provided me the opportunity to review its Privacy Practices and I understand my rights to privacy with regards to personal health information and the responsibility of Pasadena Orthopedics to properly maintain as well as disclose my health information as necessary. I give Pasadena Orthopedics consent to obtain a list of my medications from my pharmacy, and any medical records required to provide care from my other physicians.

_____ _____ or _____ _____

(Patient Signature) *(Date)* *(Patient Representative)* *(Date)*

PLEASE PRINT PATIENT NAME: _____

In an effort to remain compliant with the HIPAA privacy regulations Pasadena Orthopedics will not disclose any information to patients by telephone or facsimile without first verifying their identity.

Additionally, we will not discuss your care or the care of a minor with any friend or family member unless, specifically listed below. Please designate any person you wish to be able to call our office or obtain information about your current or future care:

NAME	RELATIONSHIP

You have the right to amend this designation at any time by filling out a new form or initiating the change in our office.