Santa Rosa Orthopaedics

Expertise. Care. Healing.

PROCESS FOR REQUESTING RECORDS

- Fill out medical Records Form correctly and entirely.
    - ***An invalid release/incomplete form will delay the process.***
- Show ID
- We legally have 15 Business days to complete your request. **
- Make sure to sign, date and check all confidential boxes.
- If you are requesting records for yourself, there is a fee of $25, no charge if sent directly to another Medical Provider.
- A $25 Charge for all Medical Records and .25 per page after 50 pages when mailing paper records.
- There is a fee of $25 for Imaging on CD (per Disc)

***** Due Date: _____ (15 Days After Signed)** ***Give to Patient***

***** DO NOT CONTACT THE OFFICE PRIOR TO THE 15 BUSINESS DAY MARK.***
*****We will contact you if the records are done prior to the 15 business days.***

If it has been 15 business days and you have not been contacted, please call Medical Records Department at but no sooner than the 15th business day:

Phone:707-546-1922 Ext. 5440

Fax: 707-546-1897

Or Email: kkraal@srortho.com

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Medical Records Request Form

***Please Fill out All Stared Fields ***

*Patient Name:	*DOB:

***Check One Box Below:

- My Complete Records (last 7 Years) -$25 Charge
- Only Records from (Date): _____ to (Date): _____
- Comments or Specific Request:

_____

_____

_____

_____

_____

(Paper Copy- $25 fee for personal records, no charge if sent to outside Medical Provider/Subpoenaed Request)

I hear by authorize _____ to release my confidential medical information and records to the physician, person, facility listed below. Information and records regarding treatment of minor, HIV, psychiatric mental health conditions or alcohol substance abuse have special rules that apply and require specific authorization.

- ***Yes___ No___*** *I authorize to release any and all records regarding drug, alcohol, or mental health treatment to the person(s) listed below.*

***Please Select Method of Delivery: ***

- Pick Up (Name):_____

  Phone Number: _____

- Fax To: _____

  Fax Number: _____

- Mail to (Name) :_____

  Address: _____

  City/State/Zip code: _____

Permission for further use or disclosure of this medical information is not granted unless another is obtained from me or unless such disclosure is specifically required or permitted by law. A Photocopy or facsimile of this authorization shall be considered as an effective and valid original document.

*Patient Signature: _____ Date: _____

This form expires 1 Year After Signed

Front Desk Use Only

Paid: Yes: _____ No: _____ ID Verified By: _____

Please Fax this Form to: 707-546-1897

Email to kkraal@srortho.com

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