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Thomas Axelrad, M.D.
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Dominic J. Mintalucci, M.D.
Garrett M. Snyder, MD.

Sarah Slough, PA-C
Leslie Manuel, PA-C
Rodney Dekleuver, PA-C

SRO Santa Rosa Orthopaedics

Expertise. Care. Healing.
1701 Fourth Street, Ste. 200 | Santa Rosa, Ca. 95404 | P 707-546-1922 | F 707-528-1602

Process for Requesting Medical Records

1. **Complete the Medical Records Request Form**
    - Forms must be filled out completely and correctly.
        1. Incomplete or invalid forms will delay processing.
    - Be sure to sign, date, and check all required confidentiality boxes.

2. **Provide Valid Photo Identification**

3. **Processing Timeline**
    - By law, we have up to **15 business days** to complete your request.
    - Please do not contact the office before the 15-day mark.
    - If your records are ready sooner, we will notify you.

4. **Fees**
    - **Personal copies of records:** $25 flat fee.
    - **Records sent directly to another medical provider:** No charge.
    - **Paper copies:** $25 for the first 50 pages, plus $0.25 per page after that.
    - **Imaging on CD:** $25 per disc.

After 15 Business Days

If you have not heard from us after 15 business days, please contact our Medical Records Department:

- **Phone:** 707-546-1922 ext. 5440
- **Fax:** 707-528-1602
- **Email:** kkraal@srortho.com

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Medical Records Request Form

Patient Name: _____ *Date of Birth:* _____

Check One Box Below:

☐ *My Complete Records* (last 7 years) – **$25 charge**

☐ *Only Records From:* _____ To _____

☐ *Comments or Specific Request:* _____

(Paper Copy – $25 fee for personal requests. No charge if records are sent directly to another medical provider or received under a subpoena.)

Authorization to Release Records

I hereby authorize Santa Rosa Orthopaedics to release my confidential medical information and records to the physician, person, or facility listed below. Please note: records released by SRO are limited to services rendered at Santa Rosa Ortho.

Sensitive Information: Yes ☐ No ☐ I authorize the release of any and all records regarding **drug, alcohol, HIV/AIDS, genetic testing, or mental health treatment** to the person(s) listed below.

Release Information To:

Name/Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Please Select Method of Delivery:

☐ *Pick Up* – Name: _____ Phone: _____

☐ *Fax To* – Fax Number: _____

☐ *Mail To* – (Name/Address/City/State/Zip): _____

Important Information:

- Further use or disclosure of these records is not permitted unless authorized by me or required/permitted by law.
- A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken.
- This authorization expires 1 year after the date signed unless I specify otherwise here: _____.

Signature

- *Patient / Authorized Representative:* _____ Date: _____
- Relationship to Patient (if not patient): _____

Med. Rec. Use Only

Paid: ☐ Yes ☐ No

Method of Payment: ☐ Cash ☐ Credit Card ☐ Check # _____

ID Verified By: _____

Please fax this form to 707-528-1602 or email to kkraal@srortho.com