Central Coast Orthopedic Medical Group

· Sean Devine, MD · Nick Caggiano, MD · Ken Fryer, MD · Otto Schueckler, MD · Daniel Woods, MD · Jeffrey Spoo, MD ·
·Dimitri Delagrammaticas, MD · Mimi Batin Van-Rooyen, MD · Dennis Blackburn, DO · James Kasper, MD ·
· Paul Castello, MD · Michael Laird, MD · Stacy Mierau, PA · Brian Kistler, MD · Marie Dusch, MD ·

Authorization for Release of Medical Records

Please send a copy of this release with requested records

Patient Information (Please print and provide complete information)

Patient Name	Date of Birth	Social Security Number
Address	**City/Zip**	**Phone**

Release From- (check the box for the correct office)

I authorize release of my medical records from:

☐ Central Coast Orthopedics
862 Meinecke Ave. Ste. 100
San Luis Obispo, CA 93405
Phone: (805) 541-4600
Fax: (805) 541-8716

☐ Central Coast Orthopedics
921 Oak Park Blvd. Ste. 204
Pismo Beach, CA 93449
Phone: (805) 473-4949
Fax: (805) 473-1802

☐ Central Coast Orthopedics
2342 Professional Pkwy. Ste. 200
Santa Maria, CA 93455
Phone: (805) 349-9545
Fax: (805) 349-8025

Release To-Name of Physician or Facility Requesting Information (Please print and provide complete information)

Please send my records to:

Physician/Facility	Phone/Fax
Address	**City/Zip**

Type of records to be released:

☐ Medical Records ☐ In-house X-rays on CD

Reason for release of information:

☐ Change of Insurance ☐ Transfer of Care ☐ Personal File ☐ Moving out of area ☐ Specialist ☐ Legal

☐ Other: _____

Please allow 15 days for processing. Incomplete information will delay processing. Use of this information for any other reason than the stated purpose is prohibited. This information is for use of the designated recipient only and cannot be provided to any other agency. ******Fee may apply-medical records department will be in contact with you.

Consent:

I authorize the release of all information, and am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol consumption and or abuse.

Signature of patient, parent, guardian, conservator, or patient power of attorney (please circle one) Date

Witnessed by:

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.