CORE ORTHOPAEDIC MEDICAL CENTER

Please allow 72 hour turn around time for all requests.

Medical Records Release
Updated 2013

Patient's name (print): _____ Date of Birth:_____

Patient's signature (Guardian/Custodian): _____

Date of Request_____ Date Mailed/Picked Up:_____

I authorize the release of my medical records as listed below from:

☐ Specific physician:_____

☐ All records

☐ I would like them faxed to:_____

☐ I will pick up records on:_____

☐ Electronic Copay (Please note we cannot send films electronically and we do not have encripted email)

☐ Please send these records to:

Doctors Name:_____

Address:_____

☐ MRI's/Xray-s*

☐ Records*

☐ Records, X-Rays and/or MRI's*

332 Santa Fe Drive, Suite 110, Encinitas, CA 92024
Phone 760-943-6700 Fax: 760-632-4292
www.coreorthopaedic.com

*Fees may apply for duplications