RODNEY Z. WONG, M.D.

Orthopedic Surgery & Sports Medicine
A Professional Corporation
Certified American Board of Orthopaedic Surgeons

515 South Drive, Suite 16
Mountain View, California 94040
(650) 967-7249

18550 De Paul Drive, Suite 201
Morgan Hill, California 95037
(408) 778-2018

Authorization for use and/or disclosure of patient health Information.

Patient's name: ____ Date of Birth: ____________________

Phone Number: _________________________________ Dates of service: _______________ to _______________

If patient is a minor, print name of parent/guardian. ____

- ❑ Mountain View Office
- ❑ Morgan Hill Office

What records will you need?;

- ❑ Complete Medical Records concerning my illness and/or treatment.
- ❑ All reports of my; ____
- ❑ MRIs, X-RAYs, CTs, PETs MR Arthrograph of my ____
- ❑ EKG, NC.
- ❑ Hospitalizations.
- ❑ Other: ____

How would patient like to obtain records? ;

- ❑ Patient will pick up in office on _________________________
- ❑ Relative/Friend will pick up patient's records on ____
- ❑ Fax records to: ____ Fax #: __________________________

By signing this form, I ____________________________________, am authorizing Rodney Z. Wong, M.D., Inc., to release my health information. I understand that the office requires 5 to 10 business days to prepare these records. I also have been informed of the $15.00 admin fee plus .25c for each copy made.

Signature _______________________________________ Date _________________

This authorization becomes effective upon signing and will expire one year from signature date.
You have the right to withdraw or revoke this authorization in writing at any time, except to the extent that Rodney Z. Wong, M.D., Inc., has already release the health information. To withdraw or revoke your authorization, please submit your request in writing to our office by mail or email.

Office use only

Records Prepared by: _________________________ Date: ______________

Notes: ____

____