Keck Hospital of USC

Authorization to Release Healthcare Information

Authorization for Use / Disclosure of information:

I voluntarily consent to and authorize my health care provider_____ to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Patient Information:

Patient Full Name: _____

Patient Date of Birth: _____

Medical Record #: _____

Recipient:

I authorize my health care information to be release to the following recipient:

Keck Medical Center of USC

Joseph Patterson MD.
Assistant Professor of Clinical Orthopaedic Surgery
Orthopaedic Trauma & Fracture Care

Health Care Consultation Center II
1520 San Pablo St., Suite 2000
Los Angeles, Ca 90033
Tel: 323-442-5986
Fax: 323-865-9513

Information to be disclosed:

I authorize the release of the following health information:

☐ All of health information that the provider has in his or her possession, including information relating to any medical history, mental of physical condition and any treatment received by me.

☐ Only the following records or types of health information:

_____

_____

_____

Patient Signature: _____ Date:_____