



South Orange County Orthopaedics, Inc.

Mark S. Ishimaru, MD Michael J. Fitzpatrick, MD Roger C. Sohn, MD
 Brinceton M. Phipps, MD Kenneth J. Wilkens, MD

26730 Crown Valley Pkwy. Ste 200, Mission Viejo, Ca 92691
949-364-2154 • FAX: 949-364-2110

MEDICAL RECORD RELEASE

I, _____ HEREBY AUTHORIZE AND REQUEST SOUTH
ORANGE COUNTY ORTHOPAEDICS TO RELEASE ALL OF MY RECORDS TO:

NAME: _____
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NAME OF PATIENT'S DOCTOR: _____
PATIENT'S SIGNATURE: _____
DATE SIGNED: _____
WITNESSED BY: _____
PATIENT PHONE NUMBER: _____

THERE IS A \$20 FEE FOR COPYING RECORDS UNLESS SENT
DIRECTLY TO ANOTHER DOCTOR'S OFFICE.