



RELEASE OF MEDICAL RECORDS - AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Send records requests to:

Fax #: 609-587-4349

Mail: 2501 Kuser Road, Hamilton, NJ 08691

Email: KSwiderski@mbortho.com

I authorize Mercer-Bucks Orthopaedics, P.C. to furnish my medical records to:

_____ Self

_____ Primary Care Physician located at: _____

Phone #: _____ Fax #: _____

All medical records and other documentation in your possession regarding the following:

(Please check option that applies)

_____ All medical records

_____ All medical records and X-rays

_____ Treatment related only to specific body part: _____

_____ Other: _____

_____ Treatment(s) beginning as of: _____ and ending on: _____

How would you like to retrieve your records?

_____ Pick up in office

_____ email: _____

_____ Fax #: _____

Please note: X-ray requests cannot be emailed or faxed.

I understand these records may contain information from other health care providers, as well as information that are administrative in nature. I specifically consent to the release of any information contained in the medical record that may relate to infection with Human Immunodeficiency Virus (HIV), AIDS, Psychiatric notes or related conditions unless I specifically denote otherwise below:

___ I do ___ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

I understand that Mercer-Bucks Orthopaedics, P.C., to transmit this information by facsimile transmission (Fax) and release Mercer-Bucks Orthopaedics, its affiliates and employees from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax.

This authorization will expire 12 months from the date of signature unless the patient has specified a shorter duration. Shorter duration expiration date: _____.

MM/DD/YY

Patient/Legal Representative Signature

Date

If signed by legal representative, please state relationship to patient: _____