

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□ Home □ Work □ Cell**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient/guardian name), authorize the use or disclosure of my protected health information as described below.

**The individual or organization below is authorized to use/disclose my protected health information to:**

MidJersey Orthopaedics

8100 Wescott Drive, Suite 101, Flemington, NJ 08822

1081 Route 22 West, Bridgewater, NJ 08807

Phone: (908) 782-0600 Fax: (908) 782-7575

**This information may be released to the following individuals or organization:**

Name of individual(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of organization/employer/physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information is being used and/or disclosed for the following purposes:**

**□** Referral to Specialist **□** Personal Use **□** Disability Forms

**□** Leaving the Practice **□** Moving out of the Area **□** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This authorization may include disclosure of information relating to genetic testing, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral/mental health information, psychotherapy notes, treatment for alcohol and drug abuse, and tuberculosis. I understand that I have the right to revoke this authorization at any time. I understand that authorizing the disclosure of this information is voluntary. I understand that the information disclosed under this authorization might be re-disclosed by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.*

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**Signature of Patient/Parent Guardian Date**



**MEDICAL RECORDS**

**The following is the fee schedule for copying medical records:**

$10.00 for copying between: 1-10 pages

$1 per page up to $100.00: 10 pages or more

$5.00 for MRI/X-Ray CD. Imaging will be burned on to a disc at patient arrival.

Payment is expected **prior** to sending or faxing any medical records.

We accept cash, credit cards, or personal checks for payment.

We will fax records when necessary and will limit the number of pages to be faxed to 10 pages or less. Please allow up to 30 days to send the required information. A valid authorization must be signed prior to releasing any information. We will not copy any records that were not created by our practice. The fee for records to be faxed is $2.

**Our practice locations are:**8100 Wescott Drive, Suite 101, Flemington, NJ 08822

1081 Route 22 West, Bridgewater, NJ 08807

Please sign below that you have read and understand our policies regarding copying of medical records.

**Name of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (908) 782-0600 Fax: (908) 782-7575 [www.midjerseyortho.com](http://www.midjerseyortho.com)