RELEASE OF MEDICAL RECORDS - AUTHORIZATION FORM

Patient Name: ________________________________ Date of Birth: ______________________

Street Address: ____

City: _______________________State: ______________________Zip: ___________________

Phone #: ______________________________

<u>Send records requests to:</u>

Fax #: 609-587-4349

Mail: 2501 Kuser Road, Hamilton, NJ 08691

Email: bcummings@mbortho.com

I authorize Mercer-Bucks Orthopaedics, P.C. and/or Mercer County Surgery Center 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: _________________

<u>How would you like to retrieve your records?</u>

______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 authorize Mercer-Bucks Orthopaedics, P.C. and/or Mercer County Surgery Center, to transmit this information by facsimile transmission (Fax) and release Mercer-Bucks Orthopaedics and/or Mercer County Surgery Center, 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: ______________________