Peter Ameglio, M.D.
Orthopedic Surgeon
Foot & Ankle Surgery

Brad Castellano, DPM
Foot & Ankle Specialty

Ronald D. Gardner, M.D.
Arthroscopic Reconstructive Surgery
Joint Replacement

Robert Martinez, M.D.
Arthroscopic Shoulder Surgery
Joint Replacement

3033 Winkler Avenue, Suite 100
Fort Myers, Florida 33916

GardnerOrthopedics.com

Phone: (239) 277-7070
Fax: (239) 277-7071

REQUEST TO OBTAIN MEDICAL RECORDS FROM OTHER FACILITIES

Patient's Name: ____ SSN#: XXX-XX-__________________

Date of Birth: ________________________ Telephone: ______________________________________

I hereby authorize and request that you release the following medical information to:

To Physician/Hospital/Facility: ______________Gardner Orthopedics____________________________

Phone: _______(239) 277-7070__________ FAX: _______(239) 277-7071____________

Address: _____3033 Winkler Avenue________________________________

City: ______Fort Myers_________ State: _____FL________ Zip:_____33916_____

INFORMATION NEEDED:

_XX_ Complete Medical Records
____ Medical Films
____ X-Ray Films
____ DEXA Bone Scan
____ Nerve Conduction Study
____ Physical/Occupational Therapy Records
____ Lab Reports
____ Operative Report
____ Prescription Information
____ Biopsy Report
____ Other ___________________________________
____

Note Special Dates of Interest: ____

SEND BY:

Courier: ______ **FAX:**__XX__ **US MAIL** ______ **To Be Picked Up** ______

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDs virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all healthcare information pertaining to such diagnosis, testing, or treatment. As required by state and federal law, Gardner Orthopedics may not use or disclose your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures on the protected health information described on the form.

I hereby authorize ____ to release information as described above.

Patient's signature or Legal Representative: ___________________________________ Date: ______________

Signature of parent or guardian: ____ Date: ______________

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REQUEST TO RELEASE GARDNER ORTHOPEDICS MEDICAL RECORDS

Please allow 5 to 10 business days for medical records to be prepared.

Purpose for Request: ______Continuing Care_______Second Opinion______Personal Record Keeping

Patient Name:____DOB:________________Phone #___________________

Address:____________________________________Apt:______City:_____________________State:_____Zip:_________

INFORMATION TO BE DISCLOSED:

_____All Medical Records

_____All Billing Records

_____All Records related to my Auto Accident

_____All Records related to my Worker's Comp Case

_____Specific date(s) of service:

____

_____X-ray Cd _____All Images

_____Specific body part:__________________

I Authorize Gardner Orthopedics to disclose the information being requested to:

_____Myself

Delivery Options:______I will pick up_________Mail to address above

_____To be picked up by___________________________Relationship______________________(Photo ID Required)

If continuing care or mailing address is different than above, please specify below:

Send to:____

Address:_________________________________Apt:_____City:___________________State:_____Zip:____________

Attention:_______________________________Phone #:_________________________Fax #:______________________

Authorization to Release Protected Information:

*****REQUIRED*****

____

Patient Signature Date: