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

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

**Brad Castellano, D.P.M.**
*Foot & Ankle Trauma*
*Sports Medicine & Reconstruction*


3033 Winkler Avenue, Ste. 100
Fort Myers, FL 33916

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

GardnerOrthopedics.com

# MEDICAL RECORDS REQUEST FORM

Patient's Name: _____ SSN#:XXX-XX-_____ DOB: _____

## INFORMATION NEEDED:

_____ Complete Medical Records
_____ Operative Report
_____ Radiology Films
_____ DEXA Scan / Nerve Conduction Study
_____ Lab Reports
_____ Physical/Occupational Therapy Records
_____ Complete Billing Records
_____ Complete Work Comp Records
_____ Complete Auto Accident Records
_____ X-ray CD ($5 fee in house)
_____Other: _____

**– FOR PATIENT RECORDS TO BE RELEASED FROM GARDNER ORTHOPEDICS–** PLEASE ALLOW 5 TO 10 BUSINESS DAYS

Purpose for Request: _____Continuing Care_____Second Opinion_____Personal Record Keeping

**Delivery options:**

_____I will pick up _____To be picked up by_____(Photo ID Required)
_____Mail to Address below
Send to:_____
Address:_____City:_____State:_____ Zip:_____
Attention:_____Phone #:_____ Fax #:_____

**– FOR PATIENT RECORDS TO BE OBTAINED FROM OTHER FACILITIES –**

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

To Physician/Hospital/Facility: _____Gardner Orthpedics_____
Address: _____3033 Winkler Ave. Suite 100_____ City: ____Fort Myers____ State: ___FL___ Zip:___33916____

SEND BY: Courier: _____ FAX:_____ 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: _____

Employee Intials_____ Date Requested_____