

# THE CENTRAL ORTHOPEDIC GROUP, LLP

651 Old Country Road, Plainview, NY 11803

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## Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize The Central Orthopedic Group to disclose/release the following information \* (check all applicable):

**For Dates of Service: From:** \_\_\_\_\_ **Through:** \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> All Orthopedic Exam notes.      | <input type="checkbox"/> X-rays images on a CD (\$5.00 fee)                  |
| <input type="checkbox"/> All Therapy Exam notes.         | <input type="checkbox"/> MRI images on a CD. (\$10.00 fee)                   |
| <input type="checkbox"/> MRI reports/diagnostic testing. | <input type="checkbox"/> Billing records / Worker's Compensation (C4) forms. |
| <input type="checkbox"/> Operative reports.              |  |

**\*\*Please note there is a charge of \$.75 per page for copies of medical records.**

**\*\*Please allow one week for processing**

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

***\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.***

\_\_\_\_\_  
Signature of patient (or patient's  
personal representative)

\_\_\_\_\_  
Printed name of patient representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative's authority to sign for patient, (ie parent,  
guardian, power of attorney for healthcare, executor)

## THE CENTRAL ORTHOPEDIC GROUP, LLP

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Frank J. Smith, RPA-C

DATE OF EXAM: \_\_\_\_\_ Account number# \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Responsible Party/ Policy Holder : \_\_\_\_\_

Insurance Company name: \_\_\_\_\_ Member Id# \_\_\_\_\_

How did the occurrence happen?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What part of the body was injured/hurt?

\_\_\_\_\_  
\_\_\_\_\_

Date of Onset: \_\_\_\_\_

Address of Onset: \_\_\_\_\_

Was this related to a Motor Vehicle accident      yes      /      no

Was this a Work related accident      yes      /      no

I affirm that the above statement is true and request the release of any monies from my insurance company to the Central Orthopedic Group, LLC.

I also give permission to the Central Orthopedic Group to release any information necessary to pay this claim to my health insurance company.

PATIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible party Signature: \_\_\_\_\_ Date: \_\_\_\_\_