THE CENTRAL ORTHOPEDIC GROUP, LLP

651 Old Country Road, Plainview, NY 11803

77 North Centre Avenue, Rockville Centre, NY 11570
5840 Merrick Road, Massapequa, NY 11758
Phone: (516) 681-8822 Fax: (516) 681-3332 www.centralorthopedicgroup.com

David Zitner, M.D.
Scott Silverberg, M.D.
Jorge Baez, M.D.
Mitchell Keschner, M.D.
Jordan Kerker, M.D.
Fernando Checo, M.D.
Crispin Ong, M.D.
Santosh Mathen, M.D,
Stelios Koutsoumbelis, M.D.
Robert Carter, M.D.
Guillermo F. Duarte, M.D.
Scott Barbash, M.D.
Shazaan Hushmendy, M.D.
Arie Dadush, M.D.
Yohan Lee, M.D.
Alan P. Wolf, M.D.
Frank J. Smith, RPA-C.
Estelle Muscat RPA-C.
Daniel Finn, PA-C.
James Bantel, PA-C.

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: _____

[ ] All Orthopedic Exam notes.
[ ] All Therapy Exam notes.
[ ] MRI reports/diagnostic testing.
[ ] Operative reports.
[ ] X-rays images on a CD ($5.00 fee)
[ ] MRI images on a CD. ($10.00 fee)
[ ] Billing ledger.
[ ] Worker's Compensation (C4) forms.

****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)

_____
Date

_____
Printed name of patient representative

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