# THE CENTRAL ORTHOPEDIC GROUP, LLP

651 Old Country Road, Plainview, NY 11803
77 North Centre Avenue, Rockville Centre, NY 11570
Phone: (516) 681-8822 Fax: (516) 681-3332 www.centralorthopedicgroup.com



## 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 records / Worker's Compensation (C4) forms.

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****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)*

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DATE OF EXAM:_____Account number#_____

PATIENT NAME: _____
Responsible Party/ Policy Holder :_____
Insurance Company name: _____ Member Id#_____

How did the occurance 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: _____