BONE & JOINT SURGEONS, INC.
Orthopedic Surgeons

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AUTHORIZATION TO RELEASE PROTECTED HEATH INFORMATION
PERMISSION TO SHARE INFORMATION

Prepayment may be required if applicable.

Patient Name: _____ Previous Names (if applicable): _____

Birth Date: ____/ ____/ ____ Social Security # (Last four Digits): XXX-XX-_____

Home Address: _____ City, State & Zip Code: _____

Phone #:_____ E-mail address if applicable: _____

Permission to Share:

I authorize Bone & Joint Surgeons, Inc., to share my individual identifiable health information, which may include protected or privileged information in written and/or verbal form.

Information to be Released

Please keep in mind if you are requesting all records on file please specify below. Please specify dates of service you are requesting. (If line below is left blank - all dates of service on file will be released with appropriate service charge of 10.00 plus .75 per each additional page if applicable).

Please indicate the dates of service you are requesting:_____

CIRCLE BELOW WHAT YOU ARE REQUESTING:

Entire File *(Including outside records)* Office Notes EKG Results Laboratory/Pathology Results Physical Therapy Reports

All Surgery Records on File Operative Reports Discharge Summaries Consultation Summaries

Itemized Billing Statements Film Reports X-Ray on CD X-Ray Films

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Purpose of Release

Reason for request:_____ In **cases where prepayment is required would you rather pay via:**

Cash, Check, or Credit Card - Please specify: _____

After records are completed please specify if you would like to pick up your records or where you would like the records sent and please provide adequate information to fulfill your request:

_____

_____

Please allow at least 5-7 business days for each request

_____ _____

Patient's Signature and/or Legal Guardian **Date Signed**