Central Jersey Orthopaedic Specialists, PA

With service provided by Copy Request
866-985-2112

Medical Records Request & Payment Form

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Day phone #: _____

City/State/Zip: _____ (*Please confirm that all patient information is correct.)*

If you would like a copy of your medical record, please read carefully and fill out all sections below. Failure to fill out all sections will delay your request. Allow 10-15 business days for processing.
One form per patient.

INFORMATION TO BE DISCLOSED

Specify information & dates to be released: _____

_____

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, hepatitis C, tuberculosis or genetics.
IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

Signature of patient/guardian/authorized representative: _____ Date: _____

____ **Please mail records to: Name**_____

Street_____

City_____ **St**_____ **Zip**_____

Phone_____

METHOD OF HANDLING

Records are billed at $10.00 for the first 10 pages then $1.00 per page to a $100.00 Maximum.

Select payment method:

____ **I would like to be billed in advance:** I have enclosed a deposit of $10.00 payable to: **COPY REQUEST.**
I understand that my chart will be copied and I will be billed in advance for the balance. Upon receipt of payment for the balance my records will be mailed.

_____ **I would like to expedite this process and pay by credit card.** Please bill these charges to my credit card.
I understand that the charges will not be specified until all work is completed and that it will not exceed $100.00.

Visa: _____ MasterCard: _____ American Express: _____ Exp Date: _____

Cardholder's Name: _____ Credit Card #: _____

Cardholder's Signature: _____ Date: _____

********** **To avoid delay, complete ALL portions of this form and mail payment to** *********

Central Jersey Orthopedics
1907 Park Ave., Suite 102
South Plainfield, NJ 07080
Fax 908-769-5308