CENTRAL JERSEY ORTHOPAEDIC, SPECIALISTS, PA
Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ ACCOUNT #: _____
MO DAY YR
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize _Central Jersey Orthopaedic Specialists, PA to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:
❑ History and physical exam	_____
❑ Progress notes	_____
❑ Lab reports	_____
❑ X-ray reports	_____
❑ Other: _____	_____
_____	_____

I specifically authorize the release of information relating to:
❑ Substance abuse (including alcohol/drug abuse)
❑ Mental health (including psychotherapy notes)
❑ HIV related information (AIDS related testing)
X_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE:
❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care ❑ Legal ❑ School ❑ Insurance
❑ Workers Compensation ❑ Other (please specify): _____

1. I understand that this authorization will expire on _____ (Print the Date this Form Expires) or 6 months after I have signed the form.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that if I am being requested to release this information by _____for the purpose of:
_____
_____

   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I understand by signing this authorization my medical records will not be sold, but under certain circumstances a fee may be charged in accordance with the New Jersey Statue.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ BY: _____
IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____