Central Jersey Orthopaedic Specialists, P.A.
Authorization for Release of Information To Specified People

Long Term 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 entire medical record & billing info to the following individuals for the purpose of continuing care.

Information to be released:
- ❑ History and physical exam
- ❑ RX
- ❑ Progress notes
- ❑ Lab reports
- ❑ X-ray reports/films
- ❑ Billing info
- 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 ❑ Treatment ❑ 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 I requesting to release this information to:

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For the purpose of:

____

- 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.
- 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
- I understand that 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