CENTRAL JERSEY ORTHOPAEDIC SPECIALISTS, PA.

Medical Records Request & Payment Form

Services provided by **Med Request Solutions Inc.** 1-800-483-6040

Patient Information

Patient Name:______________________________ Date of Birth:____________

Address:__________________________________ Day Phone:______________ **Todays Date:**___________

City/State/Zip:______________________________________ **Patient Signature:**____________________________

If you would like a copy of your medical records, please read carefully and fill out all sections below. Failure to fill out all sections will delay your request. Allow 30 business days for processing. **One Form per patient please.**
___ **Please check here if you are in need of your films.**

Information To Be Disclosed

Specify information and 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: __________

___please mail records to: Name:____

Street:____

City:_______________________ State:____ Zip:_______

Phone:____

Charge is $1.00 per page or $100 for the entire record, whichever is less. If less than 10 pages the charge is $10.00.

Select Payment Method

__ I would like to be billed in advance: I have enclosed a deposit of $10.00 payable to Med Request Solutions. I understand that my chart will be copied and I will be billed in advance for the balance. Records will be mailed upon receipt of payment for the balance.

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

VISA____ MASTERCARD____ DISCOVER____

Cardholder Name:____________________________ Credit Card #:_____________________________
Cardholder Signature:__________________________________Exp. Date:_______ Security Code:____
Billing Address:____________________________City:__________________State:_____Zip_______

*****To avoid delay, complete ALL portions of this form and mail payment to*****
Central Jersey Orthopaedic Specialists, PA
1907 Park Ave., Suite 102
South Plainfield, NJ 07080
Fax 908-769-5308