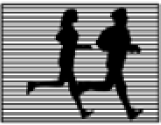
Orthopedic Associates



OF WEST JERSEY

a division of Redefine Healthcare

600 Mount Pleasant Ave Suite A
Dover, NJ 07801
Phone: 973-989-0888
Fax: 833-973-5692

Date:
Patient DOB:
Phone:
Address:

Medical Records Release

I hereby authorize:

Facility/Physician Name:

Facility/Physician Address:

Facility/Physician Address (Continued):

Facility/Physician Phone:

Facility/Physician Fax:

To Release: *

- ☐ COMPLETE RECORDS
- ☐ Progress Notes
- ☐ Procedure Reports
- ☐ History & Physical
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Diagnostic Records
- ☐ Physical Therapy Reports
- ☐ Laboratory Results
- ☐ Billing Record
- ☐ Other (specify below)

Other:

To:

Entity/Physician Name:

Entity/Physician Address:

Entity/Physician Address (Continued):

Entity/Physician Phone:

Entity/Physician Fax:

Additional Entities:

Please list any additional entities you are requesting your medical records be released to:

I understand I may revoke this consent at any time except to the extent action has been taken in reliance thereon. I understand that if I revoke this authorization I must do so in writing. Unless otherwise revoked, this authorization will expire after 1 year from the sign date. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information may be subject to redisclosure by the recipient and may no longer be protected by federal confidentially rules.

Patient/Representative Name: ______________________________________

Signature: ____

Date: ______________________