Parsippany Foot and Ankle

Medical Records/X-Ray Request and Payment Form

Patient Name: ____

Address: ____

Phone: ___________________SSN: __________________Date of Birth: _____/_____/_____

I UNDERSTAND THE FEE AS OUTLINED BELOW:

CHARGES AS FOLLOWS: $1.00 PER PAGE TO A MAX OF $50. LESS THAN 10 PAGES WILL BE PROVIDED AT NO CHARGE. WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS ON A CD DISC AT $15.00 FOR 1-3 SETS. FOR EACH ADDITIONAL SET IT IS ALWAYS $5.00. PLEASE BE REMINDED THAT WE NEED 72 HOURS TO PROCESS YOUR REQUEST FOR X-RAYS ONLY. IF YOU ARE A WORKER'S COMP PATIENT, PLEASE CONTACT YOUR CASE MANAGER TO GET AUTHORIZATION FOR ANY FILMS TO BE RENDERED TO YOU. IF A REQUEST FOR X-RAYS IS SUBMITTED. PICK UP MUST BE WITHIN 30 DAYS OTHERWISE A NEW REQUEST MUST BE SUBMITTED

If you would like a copy of your medical records or X-rays, please read carefully and fill out the sections below. Failure to fill out all sections will delay your request. Allow up to 30 business days for processing.

Information to be disclosed for services provided between the following dates:

_____/_____/_____ - _____/_____/_____

(check all applicable):

o All records o Laboratory/pathology records o X-ray/radiology records

o Billing records o Other (describe specifically) ____________________

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**

Please send the records listed above to: FAX or Mail (circle one)

Name: __________________________ Address: _________________________________

Phone __________________________ Fax: _____________________________________

This authorization shall expire no later than: ___/___/___ and may not be valid for greater than one year from the date of signature.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

___________________________________Date_________________________

Signature of patient or patient's Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare, executor

____________________________________Date____________________________

Printed name of patient representative or Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare, executor)