Fax this form to:609-394-0814
Attn: Medical Records Request

PATIENT INFORMATION
(PLEASE PRINT)

Patient Name:_____ Patient Address**:** _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ **/** _____ **/** _____ SSN #: _____ **-** _____ **-** _____

REQUESTOR/RECIPIENT INFORMATION

I hereby authorize: **Mercer – Bucks Orthopaedics**

Please disclose the following protected health information to:

Name_____

Address_____

_____

Fax: _____

Please indicate the information or types of information to be disclosed:

_____

_____

_____

Pertaining to : _____

This Request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization._____

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization. _____

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, tuberculosis or genetics.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Description of Representatives Authority Signature of Witness
(witness signature Required)

Photocopy accepted; Yes / No