Orthopedic Associates
of Dutchess County

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: _____ **Phone:** _____

Address: _____ **City/State/Zip:** _____

Please Note: A Fee of $25.00 per form (check, visa, mc or money order only) is due at the time of request.

Above listed patient authorizes the following healthcare facility to make record disclosure:

Orthopedic Associates of Dutchess County, PC

Dates and Type of information to disclose:	**The purpose of disclosure is:**
All information needed to process disability claim. This release is valid for a period of one year from the date of signature unless rescinded in writing.	**Processing of Disability Benefits**

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Initials _____

This information may be disclosed to the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____ **Phone:** _____

_____**Please mail records** _____**Please fax records to Fax:** _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **This authorization will expire 1 year from the date signed.**
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 I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to Patient

CLAIMANT INFORMATION FORM

CLAIMANT INFORMATION FOR DISABILITY/ACCIDENT-DISMEMBERMENT/FMLA/HOSPITAL INCOME CLAIMS OR DISABILITY INSURANCE FOR CREDITORS

Failure to complete this page may cause a delay in completing your claim

NAME: _____

D.O.B. _____ SOCIAL SECURITY: _____

IS THE PATIENT'S CONDITION DUE TO INJURY/SICKNESS/INVOLVING THEIR EMPLOYMENT? Y/N

LAST DATE WORKED_____

ARE YOU CURRENTLY EMPLOYED/RETIRED/OR ON PERMANENT DISABILITY? PLEASE CIRCLE

PLEASE GIVE A BRIEF DESCRIPTION OF ILLNESS OR ACCIDENT, INCLUDING THE DATE AND BODY PART

_____

_____

_____

_____

DID THE PATIENT EVER HAVE THE SAME OR SIMILAR CONDITION BEFORE? Y/N PLEASE EXPLAIN BELOW

_____

_____

_____

_____

NAME OF REFERRING PHYSICIAN/IF ANY_____

IS THIS FORM FOR YOURSELF OR THE CARE FOR A FAMILY MEMBER?_____

IS THIS FORM FOR AN UPCOMING SURGERY?_____

IS THIS FORM ONLY FOR INTERMITTENT ABSENCES? _____

ARE YOU PARTICIPATING IN FORMAL PHYSICAL THERAPY/ OCCUPATIONAL THERAPY? Y/N

PATIENT SIGNATURE_____DATE_____

CREDIT CARD FORM

Orthopedic Associates
of Dutchess County

Credit Card Payment

_____ ***I authorize Orthopedic Associates of Dutchess County, PC to Charge my card for the amount stated below.*** *(Please initial)*

_____ _____ _____ _____ (_____)

Credit Card Number – **VISA/MASTERCARD/DISCOVER/AMEX** Expiration Date

$_____

Amount to Charge Account

_____

VERIFICATION NUMBER

(for Visa/MC/Discover the three digit code can be located on the back of the card. For AMEX the four digit code can be located on the front.)

X_____

Signature of Cardholder

_____

Name of Cardholder (Please Print)

_____

Billing Address of Cardholder

_____

City, State, Zip Code

_____

Mail Payment To:

Orthopedic Associates of Dutchess County, PC
ATT: HIM Department
1910 South Rd.
Poughkeepsie, NY 12601

FOR OFFICE USE ONLY

Processed(√) Site:_____ Date: _____ Initials:_____