

Request for Form Completion

FOR OFFICE USE ONLY

Date: ___ / ___ / _____

Account #: _____

Please check form type:

Disability - \$20.00 each FMLA - \$20.00 each N/C Other: _____

Payment Method:

Cash Check #: _____ Credit Card #: ____/____/____/____ Exp: _____ CVV Code: _____
 PAYMENT NOT RECEIVED Type: Visa Mastercard Discover American Express

PATIENT PORTION

**THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED PRIOR TO PROCESSING.
PREPAYMENT IS REQUIRED. FAILURE TO DO SO MAY DELAY YOUR BENEFITS.**

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

RELEASE INFORMATION TO:

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____ Fax #: _____

Please check your preferred method of release:

- Mail the form to the patient's address
- Mail the form to the Name/Organization Above
- Fax the form to the number provided above
- I will pick up the form at the following location: Shelton Oxford Fairfield
- I will have someone pick up the form for me – Name of person to pick up: _____
Relationship: Spouse Parent Child Other

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the Valley Orthopaedic Specialists Privacy Office and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Valley Orthopaedic Specialists before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that the information in my medical record may include information relating to my treatment for mental health/psychotherapy, substance abuse and/or HIV/AIDS. ***This authorization will expire in 1 year or when I am released from my treating provider at Valley Orthopaedic Specialists.**

Signature: _____ **Date:** _____

[Patient or Authorized Representative - Relationship: Spouse Parent Other: _____]