VOS valley orthopaedic specialists

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1275 Post Rd, Ste 208
Fairfield, CT 06824
Phone: (203) 955-1202
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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: _______

Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

☐ **PAYMENT RECEIVED**

☐ **PAYMENT NOT RECEIVED**

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: __________]