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Date: _____

Patient Name: _____

Date of Birth: _____ S.S.# _____

I request and authorize Active Orthopaedics and Sports Medicine, PA to release my medical records to the physician stated below. There is a processing fee of \$1.00 per page and \$5.00 handling and postage if required with this request, an Amount established by New Jersey State Law.

Please enclose a check made payable to Active Orthopaedics or provide your credit card information with your request.

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition and/or dates: _____
- All healthcare information including X-ray films processed in our office (Additional fee of \$10.00 per xray film)
- Other _____

Signature _____ **Date Signed** _____