Arthroscopic Surgery &
Sports Medicine Center

Matthew P. France, MD

Fellow American Academy of Orthopaedic Surgeons • Arthroscopy Association of North America
Diplomate American Board of Orthopaedic Surgery • Fellowship Trained Shoulder and Knee Specialist

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Date:

Patient Name:

Authorization to Release Protected Health Information

I, ______________________________, hereby authorize the office of Matthew P. France, MD to release my medical file to the following person / facility. I understand that your office can only release the records of Dr. France and any reports contained in my file from another medical office must be requested directly from that particular office. I also understand that this release must be signed each time I request records to be forwarded or copied for my personal use. I also understand that diagnostic studies (X-Rays, MRI's, CTScans...) cannot be faxed and we cannot courier / mail them and therefore I will need to personally come to the Bedminster office to receive these.

______________________________ ______________
Patient Signature Date

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1) Please list exactly which records are being requested for release:

2) Who should these records be mailed / faxed to? Please provide full name, address, phone number and facsimile number (if applicable).

3) When do the records need to be received by?______________________________
(Please note: We will require 72 hours notification to pull your file, copy records and forward to the above)

4) If you do not want your medical records forwarded via regular mail or facsimile and you cannot personally pick up your medical records, who will be coming to the office to pick up these records for you?
Please contact the office prior to arriving to verify that the record duplication is complete. We will need to verify the identification of the individual picking up the medical records, please make sure they have appropriate identification.

______________________________ ______________________________
Printed Name Relationship