Ronald D. Gardner, M.D.
Arthroscopic Reconstructive Surgery & Joint Replacement

Robert Martinez, M.D.
Arthroscopic Shoulder Surgery Joint Replacement

Brad Castellano, D.P.M
Foot & Ankle Specialty

W. Andrew Hodge, M.D.
Hip & Knee Joint Replacement

GARDNER ORTHOPEDICS

GardnerOrthopedics.com

3033 Winkler Ave., Ste. 100
Ft. Myers, FL 33916
Ph: (239) 277-7070 Fax: (239) 277-7071

Edward R. Dupay, Jr., D.O.
Adult Reconstruction Specialist

Vidya P. Kini, M.D.
Physical Medicine & Rehabilitation

Alan Nguyen, D.O.
Physical Medicine & Rehabilitation
Interventional Spine & Sports Medicine

Madhish Patel, D.O.
Adult Reconstruction & Arthroscopy

MEDICAL RECORDS REQUEST FORM

Patient's Name: _____ SSN: XXX-XX- _____ DOB: _____

INFORMATION NEEDED:

☐ **Complete** Medical Records
☐ Operative Report
☐ Radiology Films
☐ DEXA Scan / Nerve Conduction Study
☐ Lab Reports
☐ Physical/Occupational Therapy Records
☐ **Complete** Billing Records
☐ **Complete** Work Comp Records
☐ **Complete** Auto Accident Records
☐ X-ray CD **($5.00 fee in house)**
☐ Other: _____

FOR PATIENT RECORDS TO BE RELEASED FROM GARDNER ORTHOPEDICS - PLEASE ALLOW 5-10 BUSINESS DAYS

Purpose for Request: ☐ Continuing Care ☐ 2nd Opinion ☐ Personal Record Keeping

Delivery Option:

☐ I will pick up ☐ To be picked up by _____ (Photo ID Required)

Send to:

_____

Address: _____ City: _____ State: _____ Zip:

FOR PATIENT RECORDS TO BE OBTAINED FROM OTHER FACILITIES

I hereby authorize and request that you release the following medical information to:

To Physician/Hospital/Facility: _____Gardner Orthopedics_____

Address: _____3033 Winkler Ave. Suite 100_____ City: ____Fort Myers____ State: ___FL___ Zip: ___33916____

SEND BY: COURIER: ☐ **FAX:** ☐ **US MAIL:** ☐ **To Be Picked Up:** ☐

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDs virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all healthcare information pertaining to such diagnosis, testing, or treatment. As required by state and federal law, Gardner Orthopedics may not use or disclose your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures on the protected health information described on the form.

*****I understand that requested copies of my x-rays have a cost of $5.00 per CD and requested copies of my Medical Records have a processing fee of $1.00 per page (up to 25 pages) with a cost of .25 cents per page thereafter*****

I hereby authorize _____ to release information as described above.

Patient's Signature or Legal Representative: _____ Date: _____

Signature of Parent or Guardian (if minor): _____