



"The Best Surgeons in the Joint"

ORTHOPEDIC SURGEONS

7331 College Parkway, Suite 300
Fort Myers, Florida 33907

1020 Crosspointe Dr., Suite 110
Naples, Florida 34110

Phone: (239) 337-2003 Fax (239) 337-3168

medicalrecords@jointimplant.com

Edward T. Humbert, D.O. Dennis O. Sagini, M.D. James A. Bynum, M.D. David E. Eichten, D.O.
Jeffrey S. Henn, M.D. Evgeny E. Krynetskiy, M.D. Andrés Meléndez-Dedòs, M.D. Benjamin Ditty, M.D. April Fetzer, D.O.

MEDICAL DOCUMENT FORMS RELEASE OF AUTHORIZATION

PRINT NAME _____ D.O. B. ___/___/___ PHONE: (____) _____

I HEARBY AUTHORIZE JOINT IMPLANT SURGEONS OF FLORIDA TO RELEASE COPIES OF THE FOLLOWING:

Medical Record Forms (Please Check One)

- FMLA, Disability, Other, Attending Physician, Travel Forms, Return to Work, Fitness for Duty, Workers Compensation

Preferred Return to Work Date: _____ (Physician Approval Required)

Specific Restriction: _____

Medical Records

- Office Notes (Reports Only), Operative Report, Diagnostic (XRS/MRI) (Report Only), Other

Please check the following:

- I understand there will be a \$15.00 charge for each packet the physician fills out.
I understand that ALL forms require 7 business days to be completed.

RELEASE INFORMATION TO:

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Requesting forms to be: [] FAX [] Mail [] Pick Up

PATIENT SIGNATURE _____ DATE: ___/___/___

Office Use Only

Employee Initial _____

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