Mercer-Bucks Orthopaedics

Medical Record Order Form

Patient: _____ Date:_____

Requested By: _____
Email address: _____

☐ **IF CHECKED, PLEASE SEND COPY OF SIGNED MEDICAL AUTHORIZATION**

Item	Charge	Sum
Records	$1.00 per page up to 100 pages $0.25 after 100	_____
X-rays and/or records on CD		_____
PLEASE RETURN REQUEST & INVOICE WITH PAYMENT	**Total Fee**	_____

- Make all checks payable to Mercer Bucks Orthopaedics or if paying by credit card, fill out the below information.
- Mail check or completed credit card information to address below or fax to **609-587-4349** along with original invoice.
- Include phone number and complete address on your request in the event that there are any issues regarding the release of records.
- Completion of transaction will take up to two weeks after payment is received.

Mercer Bucks Orthopaedics
2501 Kuser Rd 3rd Floor
Hamilton, NJ 08961
Attn: Medical Records Dept.

CREDIT CARD INFORMATION

Customer Name: _____ Credit Card type: ☐ Visa ☐ M/C ☐ AMEX ☐ Discover
Credit Card Number:_____ Expiration Date: _____
Name as it appears on credit card: _____ CVC2 code: _____
Payment Amount (in US Dollars): _____
Signature:_____ Date: _____

CREDIT CARD BILLING INFORMATION

Street Address: _____ City: _____ State: _____ Zip Code:_____
Country: _____ Phone Number:_____ Fax Number:_____

Any questions please call: 609-896-0444 ext. 2304
Mercer-Bucks Orthopedics Tax ID: 223572852