

3rd Party Release of Information AUTHORIZATION Form

I authorize the use/disclosure of health information about me as described below.

1. Who is releasing the information:
Upstate Orthopedics, LLP, Physician Name: _____

2. Who would you like to receive the information **(Name & Address):**
NOTE: By law, our office is unable to fax records. A complete address must be provided.

3. Description of information that may be used/disclosed (please check all that apply)
 Office notes Operative reports Discharge summaries Lab reports Radiology reports
 Disc of Images Other: _____
 List Specific Dates of service, if applicable, for the above: _____

4. The information will be used/disclosed for the following purposes: (not required for patient releases)
 Attorney Insurance Use 2nd Opinion Transfer to another MD

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

6. I understand that Practice may receive compensation for its use/disclosure of the information.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by submitting documentation to the practice except to the extent that action has been taken in reliance on this authorization. This authorization expires one year from the date signed unless otherwise directed.

Signature of Patient or Representative

Date

Patient's Name

Date of Birth

Patient's Address

PATIENT MRN

Name of Personal Representative (if applicable)

Relationship to Patient