SYRACUSE ORTHOPEDIC SPECIALISTS

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HEALTH INFORMATION USE & DISCLOSURE

Patient Name	Date of Birth	ID(For Office Use)

By signing this form, I hereby authorize SOS to disclose the health information described below to:

Person/Company: (PATIENT) _____

Address: _____ Fax#: _____

City: _____ State: _____ Zip: _____

Check all that apply: I prefer my records to be in (select one)

☐ Paper format (.75 per page/max of $6.50) ☐ CDs in PDF format/ $5 per CD ☐ CDs of radiology images/$5 per CD

Select the records you are requesting:

☒ All my health information or ☐ My Health Information for date(s) _____ through _____.

☐ Other (describe specifically) _____

Include: (Indicate by initialing):

_____ **Alcohol/Drug Treatment** _____ **Mental Health Information** _____ **HIV-Related Information**

****The documents are no longer protected by HIPAA once they leave the possession of the practice****

REASON FOR AUTHORIZATION: ☒ at my request

I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line above. In the event the health information described above includes any of these types of information, and I initial the line above, I specifically authorize release of such information to the person(s) indicated above.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

_____ _____

Patient Signature/Legally Authorized Representative Date

_____ _____

Printed Name Relationship to patient

Expiration: Release form expires 6 months from date signed unless otherwise written here._____

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.