SYRACUSE ORTHOPEDIC SPECIALISTS

Authorization for Use and Disclosure of Health Information

Please Complete **ALL** Sections

1. Patient name_____ Date of Birth_____

2. Previous name_____ ID#_____
(If applicable) (For Office use only)

On line 4 give complete name and address of whom you would like your records sent to.

3. By signing this form, I hereby authorize SOS

4. To disclose the health information described below to _____
_____
(Name and Address of Person or Organization)

5. (Check all that apply): **please fill in any specifics of what records you need.**
   - ☐ All health information
   - ☐ Health information relating to the following treatment or contion_____
     _____
   - ☐ Health information for the date(s) _____
   - ☐ Other specific description_____

6. Reason for This Authorization
   - ☐ At my request
   - ☐ Other (specify) _____has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

7. _____ _____
Patient/Legally Authorized Representative Date

8._____ _____
Printed Name Relationship to Patient

This authorization expires upon: 6 Months from Date Signed_____
(Date or description of event)

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.