New York BONE and JOINT SPECIALISTS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1 PATIENT INFORMATION:

First Name ..... Middle Name ..... Last Name .....
Patient Date of Birth ... / ... / ... Previous Name(s) .....
Home Address .....
City ..... State ..... Zip Code .....
Daytime phone ..... Email Address .....

2 I AM REQUESTING HEALTH INFORMATION IS RELEASED (☐ to ☐ from): Phone: 212-759-4553 ext. 108

ANY & ALL NY BONE & JOINT PROVIDERS/LOCATIONS - NY Bone and Joint; 205 E. 64th St., Ste. 402; New York, NY 10065; Fax: 212-486-8334
- NY Bone and Joint; 67 W. 55th St., Ste. 205; New York, NY 10065; Fax: 212-649-4601

3 I AM REQUESTING HEALTH INFORMATION BE SENT (☐ to ☐ from): ☐ SELF

OR Organization/Clinic Name ..... Attention To: .....
Mailing Address .....
City ..... State ..... Zip Code .....
FAX ..... Phone .....
Information needed by (date): ... / ... / ... (please allow 4 business days for processing)

4 INFORMATION TO BE RELEASED:

Indicate ONLY the information that you are authorizing to be released.

☐ ALL HEALTH INFORMATION ☐ CD of Images ☐ Specific dates/years of treatment .....

OR *ONLY* RELEASE INDICATED RECORDS:

☐ History Form ☐ Doctor Notes ☐ Laboratory Reports ☐ Operative Reports
☐ Radiology reports ☐ Therapy Notes ☐ Injection Notes ☐ EMG Report
☐ Radiology images ☐ Billing Statements
☐ Other information or instructions .....

THE FOLLOWING INFORMATION REQUIRES SPECIAL CONSENT BY LAW.

Even if you indicate *all health information*, you must specifically request the following information in order for it to be released and it cannot be combined with any other request.

☐ Chemical dependency program ☐ Psychotherapy notes

5 RELEASE METHOD / FORMAT REQUESTED: ☐ Paper ☐ Fax ☐ E-mail ☐ CD (images only)

6 REASONS FOR RELEASING INFORMATION: ☐ Patient's Request ☐ Review patient's current care

☐ Treatment/Continuity of Care ☐ Sharing testimonial for NY Bone and Joint's marketing purposes
☐ Other .....

I understand that by signing this form, I am requesting that the health information specified be sent to me or the third party listed above. I understand that I may revoke this request at any time in writing to NY Bone and Joint Specialists. The revocation will not apply to records already released. NY Bone and Joint Specialists will not condition treatment on whether I sign this authorization. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law.

This consent will end one year from the date the form is signed (but consents for testimonials will expire as soon as administratively practicable after your request).

....
PATIENT SIGNATURE OR AUTHORIZED PERSON SIGNATURE DATE

.....
PRINT NAME

Authorized Person's authority to sign (proof required): ☐ Patient is a Minor ☐ Legal Representative
☐ Power of Attorney ☐ Other .....

***NY Bone and Joint Specialists includes its clinics and services, as well as it's physical therapy division, All Sports Physical Therapy and any other services which are subject to HIPAA.

Records Released By: ..... Date: ... / ... / ... MR# ..... DR# .....

Updated 7/25/14