SYRACUSE ORTHOPEDIC SPECIALISTS

5719 Widewaters Parkway Syracuse, NY 13214
t: 315.883.5865 f: 315.449.9923

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:_____

City: _____ State: _____ Zip: _____

CHECK ALL THAT APPLY: **I prefer my records to be in** (select one)

☐ Paper format, I agree to pay .75 per page/ max of $6.50

☐CD's in PDF format/ $5 per CD ☐CD's of radiology images/$5 per CD

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

Select the records you are requesting:

☒ All health information or ☐Health Information for date(s)_____through_____

☐ Other (describe specifically)_____

☐**If records are for an appointment with another provider, provide the date**_____

REASON FOR AUTHORIZATION: ☒ at my request

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 certified mail, return receipt requested, to the Privacy Officer at Syracuse Orthopedic Specialists.

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, unless I check the appropriate box(es) in section 9(c). Otherwise, in the event the health information described below, in section 9(a), includes any of these types of information, and I initial the line on the box in section 9(b), I specifically authorize release of such information to the person(s) or entity indicated in Section 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing 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 (888) 392-3644 or TDD/TTY (718) 741-8300

Include: (Indicate by Initialing)

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

_____ _____
Patient Signature/Legally Authorized Representative Date

_____ _____
Printed Name Relationship to patient

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. **Expiration**: Release form expires 6 months from date signed unless otherwise written here_____.
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