Standard Authorization : Information To Be Disclosed

The information covered by this authorization includes:

___Information regarding previous treatment for
____

___Other____

Persons Authorized to Disclose Information

Physician's Name: _____________________________
130 E 77th Street
New York, NY 10075
Fax: 212 734-0407

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Name:
Address:

Fax:

Expiration Date of Authorization
This authorization is effective through ___________unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to NY Orthopedics. You should contact the Practice Administrator to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulations.

__________________________ __________________________
Name of Patient (Print or Type) Signature of Patient

__________________________ __________________________
Signature of Patient Representative Relationship to Patient

____
Date