AUTHORIZATION FOR RELEASE OF INFORMATION

NAME of PATIENT (Please Print)_____

ADDRESS_____

BIRTH DATE:_____

Information to be released from medical record. **(This section *MUST* be filled out in detail. Specifically describe the information to be used or disclosed including – but not limited to – meaningful descriptors such as date of injury, nature of injury, dates of service, etc.)**:

Medical information regarding evaluation and treatment of:

_____

_____

Information to be released **FROM:**
Rochester Community Orthopaedics, LLP
20 Hagen Dr, Suite 110
Rochester, NY 14625

Information to be disclosed **TO:**
Name _____
Address _____
City, State, Zip _____

I further authorize **RCO** to disclose this information to the designated entity via:

- ☐ US Post (if Different than above) _____
- ☐ Fax _____
- ☐ Personally picked up by patient/legal guardian _____

I_____, hereby authorize **Rochester Community Orthopaedics, LLP** to release to the above-named party the above-stated information from my medical record for the purpose of _____

I acknowledge that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Rochester Community Orthopaedics, LLP** at **20 Hagen Drive, Suite 110, Rochester, New York, 14625**. I understand that a revocation is not effective to the extent that **RCO** has relied on the use or disclosure of the protected health information. **RCO** will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to **RCO** from a third party, if applicable.

This authorization shall be in effect for <u>one-time only / 6 mo / 12 mo</u>, or 12 months if not specified.
(circle one)

_____ _____
Patient (or Personal Representative) Signature *Date*

_____ _____
Personal Representative (please print) Description of Personal Representative's Authority