

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Completed form can be mailed, emailed or faxed

**Mail:** Somers Orthopaedic Surgery & Sports Med. Group, PLLC  
Attn: Release of Information - Health Port  
664 Stoneleigh Ave., Ste. 300  
Carmel, NY 10512

**Fax:** Attn: Release of Information - Health Port  
(845) 278-4323

*Authorization Forms must be filled out completely, signed and dated by the Patient or Authorized Representative, Parent or Legal Guardian  
Somers Orthopaedics requires 14 days Advance Notice to process all Records Release and Copying Requests*

PLEASE PRINT CLEARLY

PATIENT NAME \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ADDRESS \_\_\_\_\_ S. S. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

TELEPHONE #: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

**PHYSICIAN:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> J. Buchalter, M.D. | <input type="checkbox"/> L. Foster, M.D.    | <input type="checkbox"/> N. Panaro, M.D. | <input type="checkbox"/> S. Styles, M.D.   |
| <input type="checkbox"/> D. Fauser, M.D.    | <input type="checkbox"/> V. Khabie, M.D.    | <input type="checkbox"/> A. Peretz, M.D. | <input type="checkbox"/> S. Elkowitz, M.D. |
| <input type="checkbox"/> W. Chang, M.D.     | <input type="checkbox"/> M. Bernstein, M.D. | <input type="checkbox"/> J. Yormak, M.D. | <input type="checkbox"/> S. Levin, M.D.    |
| <input type="checkbox"/> J. Park, M.D.      |   |  |  |

**OFFICE:**

- CARMEL                       NEWBURGH                       MT. KISCO                       HOPEWELL JCT.

**CASE TYPE:**

- GENERAL INSURANCE                       WORKERS' COMP.
- AUTO / NO FAULT

OFFICE MEDICAL RECORDS NUMBER: \_\_\_\_\_

**DESCRIPTION OF MEDICAL INFORMATION NEEDED:**

*(Please specify the information you wish to access by description and dates)*

- PROGRESS NOTES                       OPERATIVE REPORT(S)                       X-RAY / MRI REPORT(S)                       LABORATORY / PATHOLOGY

**ENTITY REQUESTING MEDICAL INFORMATION: (PRINT NAME, ADDRESS & TELEPHONE # BELOW)**

- PHYSICIAN                       HOSPITAL                       ATTORNEY                       SELF

**REASON FOR REQUEST:**

**SPECIFY ANY RESTRICTIONS:**

This Authorization will expire on: \_\_\_\_\_ (Not more than one year)  
DATE

*I understand that the information in my health record may include information about behavioral or mental health services, and treatment for alcohol or substance abuse, It may also include information relating to sexually transmitted disease (STD), acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection. I understand that a separate authorization is required to use or disclose confidential HIV/AIDS related information. I understand that if the person or organization I am authorizing to receive my information is not a health insurance plan or healthcare professional, the released information may be subject to redisclosure and may no longer be protected by the Federal privacy regulations. I understand that I have the right to revoke this authorization at any time and that I must submit my request in writing to Somers Orthopaedic Surgery & Sports Medicine Group, PLLC. I understand that the revocation will not apply to any disclosure(s) in response to this authorization prior to the date of the revocation.*

*I understand that I will be responsible for a copying fee and / or postage fees if applicable.  
(NYS Public Health Law Sections 17 & 18 - \$0.75 / page)*

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

AUTHORIZED REPRESENTATIVE (Signature & Print Relationship) \_\_\_\_\_

DATE \_\_\_\_\_