60 College Avenue
Nanuet, NY 10954

Phone: 845-579-2700
Fax: 845-259-1904

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize **THE SPORTS MEDZONE** to **SEND/RECEIVE (circle one)** information from the medical records of:

PATIENT NAME_____DOB_____SSN_____

PATIENT ADDRESS_____

CELL#_____HOME#_____

These records will be **SENT TO/RECEIVED FROM (circle one)**: ATTN_____

NAME OF PERSON OR FACILITY_____

ADDRESS_____

PHONE#_____FAX#_____

RECORDS TO BE SENT BY: MAIL FAX PATIENT TO PICK-UP

INFORMATION TO BE RELEASED: **(PLEASE CHECK INFORMATION REQUIRED)**

____Office Notes ____Operative Notes ____X-ray Reports ____X-ray Disk/Film ____MRI Report

____MRI Films ____Physical Therapy Notes ____Lab/Pathology Reports ____EEG,U/S, EMG/NCV

____Return to Work Note ____Disability Forms ____Billing Inquiry ____All Records Other_____

DATES OF SERVICE REQUESTED: _____

PURPOSE OF DISCLOSURE: ____Workers' Compensation ____Continued Patient Care

____Insurance ____Personal Use Other_____

• We may charge you a reasonable fee for copying and mailing of medical records.

I understand the information released is for the specific purpose above and may not be provided in whole or part to any other agency, organization, or person not listed on this authorization. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. I understand it may not be possible to ensure my right to the protection of the privacy of this information once THE SPORTS MEDZONE discloses it to another party. I understand I may revoke or terminate this authorization. This authorization will **expire in one (1) year unless a date or event is written in the blank provided below**.

EXPIRATION DATE:_____

Patient Signature_____Date_____

Signature of Patient Representative_____Relationship to Patient_____