Date: _____

791 West Genesee Street
Skaneateles, New York 13152
Tel: 315-685-7544 Fax: 315-685-7549
victorysportsmedicine.com

FOR INTERNAL USE ONLY
ACCT# _____
CSR _____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Information				
Patient's Name (Last, First, Middle):			**Date of Birth:**	
Street address:	**P.O. Box:**	**City:**	**State:**	**Zip Code:**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. I may revoke this authorization at any time by giving written notice to the office of Victory Sports Medicine & Orthopedics. However, I understand that such revocation will not affect any use or disclosure already taken in reliance upon this authorization.
2. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Once this information is disclosed to the party you requested, Victory Sports Medicine & Orthopedics cannot be responsible for that party's handling of your health information.
3. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Type of Records Requested:

Please note that there is a $0.75 per page fee for medical records copies and $5 per CD for X-Ray/MRI images. If you've visited our office for multiple body parts and dates of service, please indicate the body part and dates of service you're requesting below. If you would like copies of records for all body parts and all dates of service please check the appropriate boxes.

Body part(s):	❑ All Body Parts	Dates of service: From_____ To_____	❑ All dates of service

Records to be copied:

❑ Orthopedic Progress Notes	❑ X-ray/MRI Report	❑X-ray/MRI images	❑Op Report	❑Physical Therapy Notes	❑ All Records

Alcohol and Drug Treatment, Mental Health Treatment and Confidential HIV/AIDS-Related Information:

This authorization may include disclosure of information relating to *Alcohol and Drug Treatment, Mental Health Treatment and Confidential HIV/AIDS-Related Information* only if I place my initials on the appropriate line below. In the event the health information described in this authorization includes any of these types of information, and I initial the lines below, I specifically authorize release of such information to the person(s) indicated in the "Release To" box below.

For the following to be included, please initial:	**Initials**
Records from alcohol/drug treatment programs	
Clinical records from mental health programs	
HIV/AIDS related information	

Purpose of This Request:			
❑Personal use by patient	❑ Second opinion	❑Transfer of care	❑ Other:_____

Release To: I authorize the office of Marc P. Pietropaoli, M.D., P.C., d/b/a Victory Sports Medicine & Orthopedics **to release information to**:

Name of Provider or Facility _____

Address _____

Phone # (including area code) _____ Fax # (including area code) _____

Ending this Authorization: Select one of the following two choices:

❑ This authorization will end on the following date: _____

(Recommend 1 yr from date of request)

❑ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use or disclosure. Describe event: _____

Authorization:

I give my authorization voluntarily to release the protected medical records described above.

_____ _____

Signature of Patient or Representative Authorized by Law **Date**

_____ _____ _____

If not patient, print name of person signing form **Authority to sign on behalf of patient**

Continuity of Care:

As part of our ongoing commitment to your care, please allow Victory Sports Medicine & Orthopedics to obtain your records as part of our continuing care and completion of your records with our office. I authorize the office of Marc P. Pietropaoli, M.D., P.C., d/b/a Victory Sports Medicine & Orthopedics to obtain information from the office or provider mentioned above.

❑ This authorization will end on the following date: _____

(Recommend 1 yr from date of request)

❑ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use or disclosure. Describe event: _____

_____ _____

Signature of Patient or Representative Authorized by Law **Date**

_____ _____

If not patient, print name of person signing form **Authority to sign on behalf of patient**