AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below:

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name (Print):_____ **Date of Birth:**_____

I ALLOW:

Michael B. Lax, M.D., M.P.H.
Central New York Occupational Health Clinical Center (CNYOHCC)
6712 Brooklawn Parkway, Suite 204
Syracuse, NY 13211

TO RELEASE TO

(Must include name and address)

Physician/Facility:_____

Address:_____

City, State, Zip:_____

Purpose (please check one): ☐ Medical Evaluation/Appointment ☐ Request of Patient ☐ Other _____

Specific Description of Information (including dates):

☐ All medical records

☐ Pathology slides _____ (date)

X-ray, CT scans _____ (date)

☐ films
☐ report

☐ Other _____ (date)

The patient or the patient's representative must read the following statements:

- I understand that this authorization will expire 6 months from date of signature.
- I understand that I may revoke this authorization at any time by notifying CNYOHCC in writing, but if I do, it will not have any affect on any actions the CNYOHCC took before it received the revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Signature:_____ _____
(Patient or Legally Authorized Representative) **(Date)**

_____ Witness:_____
If legal representative, indicate relationship to patient)