Occupational Health Clinical Center (OHCC)

UPSTATE
UNIVERSITY HOSPITAL

Serving the Adirondack, Central New York and Southern Tier Regions of New York State

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:

(Must include name and address)

*Physician/Facility:____

Address:____

City, State, Zip:____

<u>*Please send this release directly to your physician/facility to release records.</u>

TO RELEASE TO

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

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

Specific Description of Information (including dates):

☐ All medical records: last three (3) years

☐ Pathology slides ______________________ (date)

X-ray, CT scans ____________________________ (date)

☐ films
☐ report

☐ Other ________________________________ (date)

The patient or the patient's representative must <u>read</u> 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)