AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:
Date of Birth:

I authorize the use or disclosure of the above named individual's health information as described below:

1. PROVIDER: The following individual or organization is authorized to make the disclosure:

2. RECORDS: The specific description of information that may be used or disclosed is as follows (include dates where appropriate): Your complete medical records pertaining to me, including any and all medical records and reports, including but not limited to office notes, laboratory and diagnostic test results and reports; radiological films and reports (including but not limited to films and reports of x-rays, CT scans and MRIs); hospital charts and records; nurses' notes' billing records; consultation report; pharmacy or medication records; and reports or other records of prior and subsequent healthcare providers received in the normal course of business.

   ___ entire record
   ___ limited record from __________ to (date) __________

3. SENSITIVE: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. RECIPIENT: This information may be disclosed to and used by the following individual or organization:

   Bottar Leone, PLLC
   AXA Tower II, Suite 1600
   120 Madison Street, Syracuse, NY 13202

   For the purpose of: releasing protected health information/medical records for litigation.

5. DURATION: I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.

6. MISCELLANEOUS: I understand I may inspect or copy the information to be used or disclosed, as provided in CFR §164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

____ ____________________
Signature of Patient Date

____
(If Not Patient, Print Name and Relationship to Patient)

A PHOTOCOPY OF THIS AUTHORIZATION SHALL HAVE THE SAME AFFECT AS THE ORIGINAL. A NOTARIZED SIGNATURE IS NOT REQUIRED BY LAW.