



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: _____

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

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 _____ Other _____
(date) (date)

films
 report

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)

If legal representative, indicate relationship to patient)

Witness: _____