

Authorization for release of protected health information



Patient information

Last name	First name	Middle Initial	Date of birth
Address	City	State	Zip
Phone #	SSN		
Date of request		Date needed	

Greater Rochester Orthopaedics, PC

General and Specialty Orthopaedic Surgery

Linden Oaks Medical Campus
30 Hagen Drive, Suite 220
Rochester, NY 14625-2658

2621 Culver Road
Rochester, NY 14609-1746

(585) 295-5476

For out of area dial 1 (800) 724-7712

Orthopaedic Surgeons

Peter N. Capicotto, MD
Spine Surgery / Scoliosis

Gregory S. Finkbeiner, MD
Foot & Ankle Reconstruction / General

Paul K. Peartree, MD
Sports Injury / Arthroscopy / General

Frank Puppato, MD
Joint Replacement Surgery

Todd Stein, MD
Hand & Upper Extremity

Physician Assistants

Margaret M. Casper, RPA-C

Thomas A. Frosini, RPA-C

Ray C. Montanaro, RPA-C

Kathleen D. Sherman, RPA-C

Leslie R. Sonders, RPA-C

Authorization Complete one box only

<input type="checkbox"/> I authorize Greater Rochester Orthopaedics to release information to: Name of provider or facility Address City State Zip Phone number (inc. area code)	<input type="checkbox"/> I authorize Greater Rochester Orthopaedics to obtain information from: Name of provider or facility Address City State Zip Phone number (inc. area code)
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Purpose for this request Check one box only

Healthcare
 Insurance coverage
 Legal
 Personal
 Other

Type of records requested Check one box only

Progress notes
 Diagnostic reports
 Operative reports
 Entire copy of my record

All medical records related to a specific illness or injury

Specify illness or injury: _____ Date(s) of treatment: _____

Authorization valid for Check one box only

This request only
 One year from the date of this authorization

Statement to release protected health information

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a **written** request to Greater Rochester Orthopaedics, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records, not to exceed 75¢ per page.

Note: Medical records are faxed in cases of medical necessity only

Signature of patient or representative _____ Date _____

Relationship to patient (if requester is not the patient) _____

FOR INTERNAL USE ONLY DATE RECEIVED: _____ DATE PROCESSED: _____ INITIALS: _____