New York Spine & Wellness Center

## AUTHORIZATION FOR NYSWC TO OBTAIN MEDICAL RECORDS ABOUT YOU

When completed and signed by you, you are authorizing the provider you have chosen to release your protected health information to New York Spine and Wellness Center.

**Patient Information (Please Print)**

**Name:** Last First Middle **Date of Birth**

**Address:** Street Address City State Zip Code

I am requesting and authorizing: _____
*(Name of provider/facility/individual who you want to release your records to us)*

_____
*(Address or fax number of the provider who will be releasing records to NYSWC)*

to release the following information *(describe information to be disclosed; be as specific and detailed as possible or broad, for example : all my medical records you have on file.)*

_____

_____

_____

Release information to: **NEW YORK SPINE AND WELLNESS CENTER** (Check one)

□ 5496 East Taft Road, North Syracuse, NY 13212 Phone: 315-552-6700 Fax: 315-552-6701
□ 6711 Glacier Creek ,East Syracuse , NY 13214 Phone: 315-703-3480 Fax: 315-703-3481
□ 5417 West Genesee St , Camillus NY 13031 Phone :315-432-4900 Fax: 315-488-4190

This authorization shall remain in effect until _____
*(Specify a date at which time this authorization will expire or write "no expiration" )*

You have the right to revoke this authorization at any time by sending written notification to the office address.

However, your revocation will not be effective to the extent that action has been taken in reliance on the authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPAA Privacy.

_____
*Patient signature /Parent/Guardian signature* *Date*

_____
*Witness signature* *Date*

***A copy must be given to the patient***