Jerald P. Vizzone, D.O.
Orthopaedic Surgery

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name_____DOB_____

Address_____

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

2. The following individual or organizations are authorized to make the disclosure: JERALD P. VIZZONE, D.O.

3. The information may be disclosed to, and used by, the following individuals or organizations :
   Name (s):_____
   Address: _____
   Purpose:_____

4. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose (s) and may include the following items (unless crossed out by me).

   Drug and alcohol abuse information
   Information regarding Human Immunodeficiency Virus, HIV including lab results
   Diagnosis of AIDS or ARC, if applicable
   History & Physical examination
   Consultations
   Genetic testing and counseling, if applicable
   Diagnostic testing, excluding HIV testing
   Discharge Summary
   Psychosocial history
   Treatment recommendations
   Other (specify):_____

5. This authorization may be revoked by me at any time except to the extent that Jerald P. Vizzone, D.O. has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the Office Manager. If not revoked by me, this consent will terminate on: _____

6. I have the right to inspect the information to be disclosed.

7. Choose One

   I understand that I need not to sign this form in order to ensure health

Care treatment, payment, enrollment in my health plan, or eligibility for benefits;

OR

I understand that if I refuse to sign this form, the organization can refuse

A. Treatment
B. Enrollment in health plan
C. Eligibility for benefits

8. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer is protected by this rule.

Signature of Patient of Legal Representative: _____

If signed by a legal representative, relationship to patient: _____

Signature of Witness: _____

Date: _____