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Russell N.A. Cecil, M.D., PH.D.

Gerald J. Ortiz, M.D.

Joseph Popper, M.D.

Authorization to release health care information

Patient: ____ DOB___________________

I or my authorized representative authorizes Mohawk Valley Orthopedics, P.C. to release my medical records dated from:____________________to_______________________

To receiving party:____

____

For the purpose of:____

____

Expiration date of disclosure: _________________________________ (Usually a year from the date of signing, unless otherwise specified)

I understand that I have a right to revoke the above authorization at any time by sending a notice in writing to the practice manager of Mohawk Valley Orthopedics, P.C. at the above address.

I further understand that release of the above requested medical records may be subject to redisclosure by the party receiving the information and may no longer be protected by the privacy rules of this practice.

____ _________________________

Signature of patient and/or authorized representative Date