ORTHOPEDIC ASSOCIATES OF LONG ISLAND, LLP

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Orthopedic Associates of Long Island, LLP to use and/or disclose certain protected health (PHI) about me to: (name) _____
(Address) _____
_____ This authorization permits Orthopedic Associates of Long Island, LLP to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.).

_____
_____
The information will be used or disclosed for the following purpose: _____

-(If requested by the patient, purpose may be listed as "the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____
{Expiration Date or Defined Event}

The practice will __ will not __ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign the authorization in order to receive treatment from Orthopedic Associates of Long Island, LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Stephen Goldstein, the Privacy Officer, at:

6 Technology Drive, Suite 100
Address

East Setauket — City:
NY — State:
11733 — Zip Code:

Signed by:_____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Patient Name: — Date:

_____
Print Name of Legal Guardian (if applicable)

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION