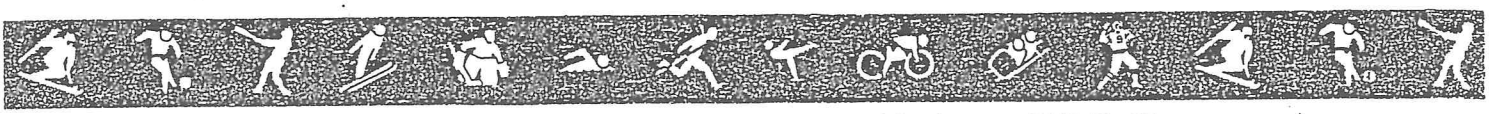

Lake Placid Sports Medicine, PLLC

William J. Smith, M.D., P.C.
Orthopaedic Surgeon

Eugene Byrne, M.D., P.C.
Orthopaedic Surgeon

Daniel P. Bullock, M.D.
Orthopaedic Surgeon

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name:_____ Date of Birth:_____

Information Requested:_____

The undersigned hereby authorizes and requested Lake Placid Sports Medicine Center, in accordance with said policies and laws, to release confidential information for the purpose of:

☐Medical Care ☐Insurance/Payment ☐Disability Determination
☐Other (please specify):_____

This information is to be released to: _____

_____

_____

_____

_____ _____
(Signature of Patient/Guardian) (Date)

_____
(Witness)

COMMENTS:_____

This authorization must be signed by the patient. If the patient is under 18, the authorization is to be signed by the parent or legal guardian. In cases of documented mental incompetence, the legal guardian must sign.

ANY DISCLOSURES OF MEDICAL INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.

_____

Date information released:
Initials of employee that released information:
Information was: ☐mailed ☐handcarried ☐faxed