LAKE PLACID
OLYMPIC TRAINING
CENTER

Official Orthopaedic Medicine Provider

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

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

Daniel P Bullock, M.D., P.C.
Orthopaedic Surgeon

Bartlomiej W. Szczech, M.D., P.C.
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: ________________________________

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____________________________________ _______________
(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

P.O. Box 790 • Church Street • Lake Placid, New York 12946 • (518) 523-1327 • Fax (518) 523-9964