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### Patients Authorization to Disclose Health Information

By completing and signing this form you authorize your healthcare provider to file medical reports with the parties you choose by checking the boxes below or naming them individually.

Failure to execute this authorization may interfere with your ability to obtain any benefits, such as social security, disability, or workers compensation benefits.

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Claimant Name	SS#	Date of Birth
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I \_\_\_\_\_, hereby authorize my treating health provider, \_\_\_\_\_, to disclose my health information, including billing records to the following parties:

- NY Workers Compensation
- My current/former Employer
- Workers Compensation insurance carrier
- No-Fault Insurance Carrier
- My Current/former private health insurance
- The following people (state relationship):

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Patient Signature	Date
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Cameron B. Huckell, M.D.  
Adult & Pediatric  
Spinal Surgery

Graham R. Huckell, M.D.  
Joint Replacement & Arthroscopy  
General Orthopedics

A. Marc Tetro, M.D.  
Hand, Shoulder & Elbow Surgery,  
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