Thomas Youm, MD

RYC Orthopaedics, PC
1056 Fifth Avenue, NY, NY 10028
(212)348-3636 Fax(212)410-3338

HIPAA AUTHORIZATION FORM

Name_____ Date of Birth_____

Address _____

I hereby authorize use of protected health information about me as described below.

1. The following person/class of person/facility is authorized to use or disclose information about me: ***Thomas Youm, MD, RYC Orthopaedics, PC, 1056 5th Avenue, NY, NY 10028***

2. The following person may receive disclosure of protected health information about me:

Name & Address:_____

3. The specific information that should be disclosed : ____(check) All information

Or specify:_____

Unless you sign here, no information about alcohol, substance abuse, HIV/AIDS, or mental health will be disclosed: Yes, disclose this information _____

No, do not disclose _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulation.

5. I may revoke this authorization by notifying ***Thomas Youm, MD***, in writing of my desire to revoke it. However, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on _____. OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me.

Signature:_____ Date:_____

Or, if applicable:

Signature Guardian_____ Date:_____