HOSPITAL FOR SPECIAL SURGERY

WHERE THE WORLD COMES TO GET BACK IN THE GAME

Seth Jerabek, MD

Adult Reconstruction & Joint Replacement Surgeon

Hospital For Special Surgery

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Authorization for Release of Medical Records

NOTE TO PATIENT: KINDLY SIGN AND DATE THIS FORM BELOW

By signing this form, I authorize your office to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Limitations on the information you may release subject to this Release Form are as follows:

N/A

Release my protected health information to the following person(s)/entity:

Name: _____SETH JERABEK_____

Address: ____535 E 70th Street, NY, NY 10021_____

City: ____NEW YORK_____ State: _____NY_____ Zip: _10021__

Patient Signature: **Date:**