Varus Orthopaedics

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August 7, 2018

After many years in private practice, I am pleased to announce I will be joining St. James Hospital as an employed physician, effective August 20, 2018. I will continue to serve both the Hornell and Wellsville communities by seeing patients in Hornell at St. James Hospital's Orthopaedic Clinic, located at 432 Canisteo Street (across the street from the hospital), and in Wellsville at Jones Memorial Hospital's Orthopaedic Clinic located at 191 North Main Street (inside the hospital on the first floor).

After August 20, 2018, appointments can be made by calling (607) 324-8121 and in Wellsville at (585) 596-2054.

St. James Mercy Hospital will hold and maintain all of the medical records located at the office for any active patient between August 20, 2015- August 19, 2018. Your medical records though are confidential, and all patients have a right to have a copy transferred to another physician, or released to you or another person you designate, if you so choose. If you plan to continue with Dr. Halpenny, you can indicate so by completing and signing the attached authorization to release your records to St. James Hospital and mailing it back to the office at 432 Canisteo Street, Hornell, NY 14843, or you may fax it to (607) 324-8124. If you choose to see a different physician, please complete and sign the enclosed Authorization for Release of Health Information Pursuant to HIPAA and return it to the office, at 432 Canisteo Street, Hornell, NY 14843 as soon as possible so we may transfer copies of your records to your new physician.

If you have any questions or concerns, please contact our Hornell office at (607) 324-3295. The Varus Orthopaedics Hornell office will remain open through the end of 2018 for administrative services only. All clinical services will move on August 20, 2018.

I look forward to continuing to serve as your orthopaedic provider at the new offices.

Very Truly Yours,

John Halpenny, MD

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**