KAYAL ORTHOPAEDIC CENTER, P.C.

CASTLE CONNOLLY TOP DOCTORS
CASTLE CONNOLLY
2011–2020

TOP DOCTOR 2020
TOP DOCS
2011–2020

Robert A. Kayal, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Founder, President & CEO
Chairman, Department of Orthopaedic Surgery

Orthopaedic Surgeons
Edward C. Friedland, MD, FAAOS
E. Jeffrey Pope, MD, FAAOS
Amit Sood, MD, FAAOS
Edward A. Lin, MD, FAAOS
Aaron J. Greenberg, MD
Victor Ortiz, MD
Kevin S. Finnesey, MD, FAAOS
Paul Kovatis, MD

Foot & Ankle Surgeon
Chad W. Rappaport, DPM, FACFAS

Podiatrist
Theresa Ronna, DPM

Physiatrist
Steve M. Aydin, DO

Rheumatologists
Alan Zalkowitz, MD
Rajesh K. Pandey, MD
Irina Raklyar, MD, FACR

Primary Care Sports Medicine
Michael Loreti, MD

Physician Assistants
Michael G. Kayal, RPA-C
Dean P. Mellas, PA-C
James J. Verardi, PA-C
Roya Rahimi, PA-C, CNMT
Michael T. Booth, PA-C
Jennifer M. Castellanos, PA-C
Vivek A. Desai, PA-C
Robert A. Villa, PA-C
Jesse Markowitz, PA-C
Erin Cieslak, PA-C
Joel Marrero, PA-C

Chiropractors
Mark Leichter, DC, CFMP
James D. Lupi, DC, CFMP
Gino S. Ramundo, DC
Giselle M. Savoia, DC
Harout Tchoulhakian, DC

Occupational Therapist
Mary Chris Bassman, OTR, CHT

Physical Therapists
Elvin G. Luyun, PT, DPT
Jon-Joseph P. Lozado, PT
Cherrilyn Garcia, PT, DPT
Dheeraja Byreddy, MPT
Alexander M. Estacio, PT
Aldou Cinco, PT
Anna Templo, PT, DPT
Krystle Ardiente, PT
Harjot Garry Singh, PTA

HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address:_____

I hereby authorize: KAYAL ORTHOPAEDIC CENTER, P.C. to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to:_____

Please indicate the information or types of information to be disclosed (including dates if necessary):_____

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to KAYAL ORTHOPAEDIC CENTER, P.C.

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for drug and/or alcohol abuse, mental health, sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS). This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

Patient or Legal Representative: _____
Date: _____

Representative's authority to act on behalf of individual: _____Witness: _____