NewYork-Presbyterian | Weill Cornell Medicine | Columbia University Irving Medical Center

| PATIENT Name (please print): | Middle or Other Name (please print): | Patient Date of Birth: / / |
|---|---|---|
| Patient Street Address (please print): | | Patient Apt/Unit/Suite (please print): |
| Patient City (please print): | Patient State (please print): | Patient Zip (please print): |
| Patient Telephone: ( ) | Patient Fax Number (if applicable): | Patient Email address (please print): |

RECIPIENT Name (please print): Please check if same as above and skip to next section : ☐

| Recipient Street Address (please print): | | Recipient Apt/Unit/Suite (please print): |
|---|---|---|
| Recipient City (please print): | Recipient State (please print): | Recipient Zip (please print): |
| Recipient Telephone: ( ) | Recipient Fax Number: ( ) | Recipient Email address (please print): |

REQUEST REASON, please indicate the purpose of the record release:

☐ Patient Request ☐ Care at another facility/provider ☐ Life Insurance
☐ Legal Purposes ☐ Disability ☐ Worker's Comp
☐ Other (please specify): _____

DISCLOSING ENTITY please check the name(s) of the center(s) to disclose information or choose Other Healthcare Provider and specify:

Hospital/Inpatient Locations

☐ NYP/Allen Hospital ☐ NYP/Lawrence ☐ NYP/Weill Cornell Medical Center
☐ NYP/Brooklyn Methodist ☐ NYP/Lower Manhattan ☐ NYP/Westchester Division
☐ NYP/Columbia University Medical Center ☐ NYP/Morgan Stanley Children's Hospital ☐ Gracie Square Hospital
☐ NYP/Hudson Valley ☐ NYP/Queens

Outpatient/Provider(s) Offices/NYP Physician Medical Groups: For outpatient/physician office records only, please print provider(s) name(s):

☐ Columbia University Irving Medical Center (CUIMC) _____
☐ Weill Cornell Medicine (WCM): _____
☐ NYP Medical Group Brooklyn: _____
☐ NYP Medical Group Hudson Valley: _____
☐ NYP Medical Group Queens: _____
☐ NYP Medical Group Westchester: _____

Ancillary Services

☐ NYP Radiology (imaging only) ☐ Weill Cornell Imaging at NYP
☐ NYP Laboratory (pathology slides only) ☐ Columbia Dental Medicine

Other Healthcare Provider (please specify and print name of provider/entity):

_____

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INFORMATION TO BE RELEASED, please specify which medical records should be released:
Dates of Service: from ____/____/____ to ____/____/____ (records will not be released unless Date of Service section is complete)

Medical Records to be Released:

☐ Entire Medical Record ☐ Inpatient/Hospital Records ☐ Outpatient / Provider(s) Office Records ☐ Dental Record

Specific Records to be Released Only:

| | | |
|---|---|---|
| ☐ Hospital Admission Records Only | ☐ Operative Reports Only | ☐ Discharge Summaries |
| ☐ Emergency Department Only | ☐ Ambulatory Surgery Records | ☐ Itemized Billing Statement |
| ☐ Radiology Reports Only | ☐ Radiology Images/Studies Only | ☐ Laboratory Reports Only |
| ☐ Provider Notes Only | ☐ Consult Reports Only | ☐ Immunization List Only |

Other Records to be Released (please specify): _____

ADDITIONAL AUTHORIZATION TO RELEASE SENSITIVE INFORMATION, records containing sensitive information **will be only released** if the appropriate items are initialed by the patient/authorized representative below (each section to be released must be initialed):

_____Alcohol/Drug Treatment/Testing Records _____HIV/AIDS Related Information

_____Mental Health Testing/Treatment (except psychotherapy notes) _____Genetic Testing Information

OTHER COMMENTS/NOTES:

RELEASE METHOD, when possible, we will provide the information you requested electronically please check your preference:

☐ Paper ☐ Fax ☐ Email (unsecure method)

☐ CD ☐ Flash Drive (if available)

☐ Patient Portal Only patients with an active account can request electronic delivery via secure web patient portal at no cost.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS, please review and sign. I, or my authorized representative, request that health information regarding my care and treatment be disclosed as described on this form. I understand that:

1. I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
2. Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
3. Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP/CUIMC/WCM will not release your records.
4. By my specifically authorizing the release of sensitive information (i.e., HIV/AIDS related alcohol or drug treatment, mental health treatment information, and genetic testing information) that the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of sensitive information, I may contact the New York State Division of Human Rights 1-888-392-3644 or the New York City Commission of Human Rights at (718) 722-3131. These agencies are responsible for protecting my rights.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in Item 4 above) and redisclosure may no longer be protected by federal or state law.
6. I may revoke this authorization at any time by providing written notice to NYP/CUIMC/WCM except to the extent that action has already been taken based on this authorization.
7. I understand that this Authorization will expire on (enter date): ____/____/____ or 1 year after being signed.

Signature of Patient/Authorized Representative: _____ Date: ____/____/____

If Authorized Representative, please print name and relationship to patient and provide supporting documentation as appropriate:

Name: _____ Relationship: _____