Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

*Please bring all completed forms to your appointment*

*(Office use)*

## GENERAL MEDICAL RECORDS RELEASE FORM

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) & MEDICAL RECORDS

(Please print clearly)

Name: _____ DOB: _____ Date: _____

Address: _____

Phone #: _____

***Medical Records Release:***

**I hereby authorize Weill Cornell Imaging at NewYork-Presbyterian (WCINYP) to release the following Protected Health Information (PHI)* from my medical records in the event that a health care provider, the referring physician, or I have requested, or if I should make a records request in the future up to one (1) year from the Date of Service.**

*PHI: Protected Health Information is any information pertaining to health status, provision of health care, or payment for health care that can be linked to a specific individual. This may include any part of a patient's medical record or payment history.

**By signing this document, I understand that:**

1. I may inspect or receive a copy of the Protected Health Information described by this Authorization.
2. This authorization is voluntary and I have the right to refuse to sign it.
3. I may revoke this authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice. Such revocation would not affect any action taken by WCINYP in reliance to this Authorization before receipt of my written revocation.
4. This Authorization will expire on_____/_____/_____ (fill-in if less than 1 year) or 1 year after being signed.

X_____ _____ _____ _____

Signature of Patient or Personal Representative | Print name if representative | Relationship to patient | Date

**OFFICE USE ONLY**

**Request Filled by:**

Name (Print): _____

CWID: _____

Date: _____

ACCESSION#:_____

**OFFICE USE ONLY**

NOTES: