

**Division of Clinical Genetics**  
**CHILDREN'S HOSPITAL OF NEW YORK**  
3959 Broadway BH7N726-B, New York, NY 10032  
(212) 342-4622 ♦ (212) 305-9058 FAX



## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION/MEDICAL RECORDS

### PATIENT INFORMATION:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Release information to:

The DISCOVER Program  
Children's Hospital of New York  
Division of Clinical Genetics  
3959 Broadway, BH7N 726-B  
New York, NY 10032

Send to: Joy Tanaka, PhD  
Email: at3024@cumc.columbia.edu  
Phone: (212) 342-4622  
Fax: (212) 305-9058

☐ I hereby authorize the DISCOVER program to obtain information indicated below that is contained in my patient records to the recipient above.

*Including patient histories, offices notes, laboratory test results, genetic test results, developmental evaluation, radiology studies, films, referrals, consults, and records sent to you by other health care providers.*

☐ **Include information regarding Alcohol/Drug treatment, Mental Health treatment (except psychotherapy notes), and/or HIV/AIDS related information.**

\_\_\_\_\_  
*Signature of Patient or Legal Guardian*

\_\_\_\_\_  
*Printed Name*

Date: \_\_\_\_\_

\_\_\_\_\_  
*Relationship if not patient*