Weill Cornell Medical College (WCMC)
Privacy Office
Forms

FAX: 646-962-0332

Authorization To Use or Disclose Health Information

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ Phone: _____

ST: _____ Zip: _____ NYP#: _____ (if available)

I authorize the release of the following information:

- ☐ Entire medical record
- ☐ Diagnostic Tests — Date(s): _____
- ☐ Doctor's Notes (from Dr. _____) — Date(s): _____
- ☐ Lab Results — Date(s): _____
- ☐ Pathology Reports _____ Specimens _____ — Date(s): _____
- ☐ Radiology Reports _____ Images _____ — Date(s): _____
- ☐ Medical Record/Information from outside the institution brought to the practice by me (explain): * FEE ASSOCIATED *
- ☐ All of the above with the exception of: _____
- ☐ Other: _____

Who will release information:
Name: WEILL CORNELL MEDICAL COLLEGE
Address: 1305 YORK AVENUE 6TH FLOOR
City, State, Zip: NEW YORK, NY 10021

Who will receive information:
Name: _____
Address: _____
City, State, Zip: _____

*** THIS AUTHORIZATION EXPIRES WHEN RECORD IS RECEIVED ***

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care
- I may revoke this authorization at any time before the information I have requested is released by completing a "Request to Revoke An Authorization" form, which is available at this office
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Weill Cornell Medical College shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements
- I may request a copy of this signed form
- Weill Cornell Medical College may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient

WMC, please indicate date completed: _____, retain this form in the patient's file, and provide a copy to the requestor

*** 1st COPY IS FREE OF CHARGE. DUPLICATES ARE .75 PER PAGE ***

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released: _____

_____

Describe information to be released: _____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any:

_____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

_____

_____

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

DOH-2557 (2/11)