Weill Cornell Medicine
Primary Care

Location:

MEDICAL RECORD RELEASE FORM

Patient Name _____ Date Of Birth _____ MRN _____

I authorize Weill Cornell Medical Associates to release a copy of my medical record to:

_____

Please provide record via:

☐ Regular mail Address: _____

☐ **Secure E-Mail PDF** (preferred). E-mail address: _____

☐ Fax Fax Number: _____

My physician at Weill Cornell Medical Associates is/was: _____

Reason for Request:

☐ Moving ☐ Change Insurance ☐ Transferring Care ☐ Release to Specialist ☐ Other: _____

I specifically authorize the release of the following:

☐ Past 6 months of notes ☐ 12 months ☐ 2 years ☐ 3 years ☐ Other _____

☐ Last Physical Exam (notes and lab work)

☐ Last Lab Test(s) _____

☐ Immunization (vaccination) records ☐ Other (Please specify): _____

Comments/Notes: _____

I understand that:

By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.

I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

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 Associates 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 Associates 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

This release is valid for 90 days from the date signed, unless otherwise specified as follows: _____

Patient/Representative Signature _____ Date: _____

Print Name _____ Relationship To Patient: _____

YOU MUST COMPLETE, PRINT, SIGN, AND FAX OR MAIL FORM TO PRACTICE

Reset Form Print Form