

43530

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS**

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| --- | --- | --- |
| Patient Name (please print): | Maiden or Other Name (please print): | Patient Date of Birth: |

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| --- | --- | --- | --- | --- | --- |
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|  | |  |  |  |  |
| Patient Address (please print) | |  |  |  |  |
|  | |  |  |  |  |
| Telephone (Area Code and Number): | | Email address (please print): |  | Medical Record Number: |  |
| ( | ) |  |  |  |  |
|  | |  | |  |  |
| Name, address and telephone number of Person(s) or Entity to whom this Information will be sent. Please check If same as above | | | | |  |
| Send to (please print): | |  |  |  |  |
|  | |  |  |  |  |
| Address (please print): | |  |  |  |  |
|  | |  |  |  |  |
| Telephone (Area Code and Number): | |  |  |  |  |
| ( | ) |  |  |  |  |
|  | | |  |  |  |
| Check the name of the Center to disclose information or choose Other Healthcare Provider (specify): | | |  |  |  |
| NYP/Columbia University Medical Center (NYP/Allen Hospital; NYP/Morgan Stanley Children’s Hospital) | | | NYP/Weill Cornell Medical Center | |  |

NYP/Westchester Division NYP/Lower Manhattan Other (Provide Name of Entity)

(please print)

Specify Information to be released (medical records will not be released unless a date of service(s) is identified on this form):

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical Record from (insert date) | | |  |  |  | to (insert date) | |  | |  |
| Hospital Admission | | Emergency Department | | Ambulatory Surgery | | Outpatient | | | |  |
| Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.): | | | | | | | | | |  |
|  |  | | | | | |  | |  |  |
| Include (Indicate by Initialing below): Please note that the information will not be released if not initialed. | | | | | | | | | |  |
|  | Alcohol/Drug Treatment | | |  |  |  |  |  | HIV/AIDS Related Information |  |
|  | Mental Health Treatment (except psychotherapy notes) | | | | |  |  |  | Genetic Testing Information |  |

Please consider the environment. When possible, NewYork-Presbyterian will provide the information you requested electronically please check preference: CD/DVD Electronic Delivery

Patients with an active myNYP.org account can request electronic delivery via secure web patient portal at no cost. Please confirm and initial below:

***•*** I have an active myNYP.org account and understand the medical record(s) I requested will be sent to myNYP.org account;

***•*** If my medical record(s) cannot be delivered to myNYP.org account it will be mailed to the above-stated address on CD/DVD

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| --- | --- | --- | --- |
| Patient or Personal Representative Initial | | |  |
| The purpose(s) for which disclosure is authorized (check where applicable): Individual’s request Medical CareInsuranceImmunizationLegal | | |  |
| Other (specify): | (please print) | |  |
|  |  |
| I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) be disclosed as described | | | | |
| on this form. I understand that: | |  | | |
| ***•*** I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below. | | | | |
| ***•*** Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying. | |  | | |
| ***•*** Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP will not release your | | | | |
| records. | |  | | |
| ***•*** By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from | | | | |
| re-disclosing 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 HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights | | | | |
| at (212) 306-7450. These agencies are responsible for protecting my rights. | |  | | |
| ***•*** Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements | | | | |
| regarding prohibition of re-disclosure. | |  | | |
| ***•*** I may revoke this authorization at any time by providing written notice to NYP except to the extent that action has already been taken based on this authorization. | | | | |
| ***•*** I understand that this Authorization will expire on: Date \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ (provide date if less than 1 year) or 1 year after being signed. | | | | |
| Signature of Patient/personal representative (e.g., legal guardian) | | Date | | |
| If personal representative, print name and relationship to patient | |  | | |
| Witness or Notary | |  | | |

538498 (07/14)



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**MEDICAL CORRESPONDENCE UNITS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SITE** | **MAILING ADDRESS** | **IN PERSON ADDRESS** | **TELEPHONE** |  |
| **NUMBER** |  |
|  |  |  |  |
| NewYork-Presbyterian Hospital / | 622 West 168th Street | 177 Fort Washington Avenue | (212) 305-3270 |  |
| Columbia University Medical Center | Medical Correspondence Unit | Milstein Lobby |  |  |
| Morgan Stanley Children's Hospital | New York, NY 10032 | New York, NY 10032 |  |  |
| of NewYork-Presbyterian Hospital |  |  |  |  |
| (CHONY) |  |  |  |  |
| The Allen Hospital (TAH) |  |  |  |  |
| NewYork-Presbyterian Hospital / | 525 East 68th Street | 525 East 68th Street | (212) 746-0530 |  |
| Weill Cornell Medical Center | Medical Correspondence Unit | Room P-04 |  |  |
|  | Box 126 | New York, NY 10065-4879 |  |  |
|  | New York, NY 10065-4879 |  |  |  |
|  |  |  |  |  |
| NewYork-Presbyterian Hospital / | 21 Bloomingdale Road | 21 Bloomingdale Road | (914) 997-5725 |  |
| Westchester Division | Medical Correspondence Unit | Main Lobby – See Security |  |  |
|  | Hall H, Room 006 | White Plains, NY 10605 |  |  |
|  | White Plains, NY 10605 |  |  |  |
|  |  |  |  |  |
| NewYork-Presbyterian Hospital / | 170 William Street | 170 William Street | (212) 312-5121 and |  |
| Lower Manhattan | Medical Correspondence Unit | Room M92 | (212) 312-5122 |  |
|  | Room M92 | New York, NY 10038 |  |  |
|  | New York, NY 10038 |  |  |  |
|  |  |  |  |  |