



New York-Presbyterian

The University Hospital of Columbia and Cornell
43530



Weill Cornell
Medicine



ColumbiaDoctors
The Physicians and Surgeons
of Columbia University

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Patient Name (please print):		Maiden or Other Name (please print):	Patient Date of Birth: / /
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 <input type="checkbox"/> Send to (please print):			
Address (please print):			
Telephone (Area Code and Number): ()	Fax (Area Code and Number): ()		
Check the name of the Center to disclose information or choose Other Healthcare Provider (specify): Hospital/Inpatient <input type="checkbox"/> NYP/Columbia University Medical Center (NYP/Allen Hospital; NYP/Morgan Stanley Children's Hospital) <input type="checkbox"/> NYP/Weill Cornell Medical Center <input type="checkbox"/> NYP/Westchester Division <input type="checkbox"/> NYP/Lower Manhattan <input type="checkbox"/> NYP/Lawrence <input type="checkbox"/> NYP/Brooklyn Methodist <input type="checkbox"/> NYP/Hudson Valley <input type="checkbox"/> NYP/Queens Outpatient/Physician's Office <input type="checkbox"/> Columbia Doctors (outpatient/physician's office record only) please print your physician's name: _____ <input type="checkbox"/> Weill Cornell Medicine (outpatient/physician's office record only) please print your physician's Name: _____ <input type="checkbox"/> Other (Please print Name of Entity) _____			
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) __/__/__ <input type="checkbox"/> Hospital Admission <input type="checkbox"/> Emergency Department <input type="checkbox"/> Ambulatory Surgery <input type="checkbox"/> Outpatient / Physician's Office Records Only Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.): _____			
Note: If you need the Radiology/X-Ray images, please send a copy of this request to Radiology at the facility where the procedure was performed.			
Include (Indicate by Initialing below): Please note that the information will not be released if not initialed. _____ Alcohol/Drug Treatment/Testing _____ HIV/AIDS Related Information _____ Mental Health Testing/Treatment (except psychotherapy notes) _____ Genetic Testing Information			
Please consider the environment. When possible, we will provide the information you requested electronically please check preference: <input type="checkbox"/> CD <input type="checkbox"/> DVD <input type="checkbox"/> Flash drive (with restrictions) <input type="checkbox"/> Electronic Delivery (to MyChart/myNYP.org portal, if available, appropriate) <input type="checkbox"/> E-mail, (not secure)			
Patients with an active electronic medical records account (patient portal) can request electronic delivery via secure web patient portal at no cost. Please confirm and initial below: I have an active patient portal account and understand the medical record(s) I requested will be sent to my patient portal account <u>at</u> <input type="checkbox"/> MyChart/myNYP.org If my medical record(s) cannot be delivered to my patient portal account it will be mailed to the above-stated address on an encrypted portable media (e.g. CD/DVD, Flash drive [with restrictions], etc.) Patient or Personal Representative Initial _____			
The purpose(s) for which disclosure is authorized (check where applicable): <input type="checkbox"/> Individual's request <input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> Immunization <input type="checkbox"/> Legal <input type="checkbox"/> Other (specify): _____ (please print)			

I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) or Columbia Doctors (CD) or Weill Cornell Medicine (WCM) 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 / CD / WCM 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 / CD / WCM 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: Name of Personal Representative _____ Relationship _____

Witness/Notary _____