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

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

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.**

_____ _____ Date: _____
Signature of Patient or Legal Guardian *Printed Name*

_____
Relationship if not patient