NewYork-Presbyterian Weill Cornell Medicine COLUMBIA
COLUMBIA UNIVERSITY IRVING MEDICAL CENTER

PATIENT Name (please print):	Middle or Other Name (please print):	Patient Date of Birth: / /
Patient Street Address (please print):		Patient Apt/Unit/Suite (please print):
Patient City (please print):	Patient State (please print):	Patient Zip Code (please print):
Patient Telephone: ( )	Patient Email address (please print):	

RECIPIENT Name (please print): **Please check if same as above and skip to next section :** ☐		
Recipient Street Address (please print):		Recipient Apt/Unit/Suite (please print):
Recipient City (please print):	Recipient State (please print):	Recipient Zip Code (please print):
Recipient Telephone: ( )	Recipient Fax Number: ( )	Recipient Email address (please print):

REQUEST REASON, please indicate the purpose of the record release:

- ☐ Patient Request
- ☐ Legal Purposes
- ☐ Other (please specify): ______________________________
- ☐ Care at another facility/provider
- ☐ Disability
- ☐ Life Insurance
- ☐ Immunization
- ☐ Worker's Comp

DISCLOSING ENTITY please check the name(s) of the center(s) to disclose information or choose Other Healthcare Provider and specify:

Hospital/Inpatient Locations

- ☐ NYP/Allen Hospital
- ☐ NYP/Brooklyn Methodist
- ☐ NYP/Columbia University Medical Center
- ☐ NYP/Hudson Valley
- ☐ NYP/Westchester
- ☐ NYP/Lower Manhattan
- ☐ NYP/Morgan Stanley Children's Hospital
- ☐ NYP/Queens
- ☐ NYP/Weill Cornell Medical Center
- ☐ NYP/Westchester Behavioral Health
- ☐ Gracie Square Hospital
- ☐ NYP/ The One

Outpatient/Provider(s) Offices/NYP Physician Medical Groups: For outpatient/physician office records only, please print provider(s) name(s):

- ☐ Columbia University Irving Medical Center (CUIMC): ______________________________
- ☐ Weill Cornell Medicine (WCM): ______________________________
- ☐ NYP Medical Group Brooklyn: ______________________________
- ☐ NYP Medical Group Hudson Valley: ______________________________
- ☐ NYP Medical Group Queens: ______________________________
- ☐ NYP Medical Group Westchester: ______________________________

Ancillary Services

- ☐ NYP Radiology (imaging only)
- ☐ NYP Laboratory (pathology slides only)
- ☐ Weill Cornell Imaging at NYP
- ☐ Columbia Dental Medicine

Other Healthcare Provider (please specify and print name of provider/entity):

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INFORMATION TO BE RELEASED, please specify which medical records should be released:
Dates of Service: from ____/____/____ to ____/____/____ (records will not be released unless Date of Service section is complete)

Medical Records to be Released Only:

- ☐ Full Medical Record
- ☐ Emergency Department Only
- ☐ Radiology Reports Only
- ☐ Provider Notes Only
- ☐ Operative Reports Only
- ☐ Ambulatory Surgery Records
- ☐ Radiology Images Only
- ☐ Consult Reports Only
- ☐ Discharge Summaries
- ☐ Itemized Billing Statement
- ☐ Laboratory Reports Only
- ☐ Immunization List Only
- ☐ Pathology Slides
- ☐ Pathology Report Only
- ☐ Medical Record Abstract (History & Physical, Discharge Summary, Operative Reports, Consultations, Labs, Pathology and Radiology Reports)

Other Records to be Released (please specify): ______________________________

ADDITIONAL AUTHORIZATION TO RELEASE SENSITIVE INFORMATION, records containing sensitive information **will only be released** if the appropriate items are initialed by the patient/authorized representative below (each section to be released must be initialed):

________Drug and/or Alcohol abuse diagnosis and/or Treatment

________HIV/AIDS diagnosis and/or treatment

________Psychological/Psychiatric Conditions (Except Psychotherapy Notes)

________Genetic Testing

OTHER COMMENTS/NOTES:

RELEASE METHOD, when possible, we will provide the information you requested electronically. Please check your preference:

- ☐ Paper
- ☐ Fax
- ☐ CD
- ☐ Email
- ☐ Patient Portal (Only patients with an active account can request electronic delivery via secure web patient portal at no cost).
  Visit www.nyp.org/patientportal to create an account

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS, please review and sign. I, or my authorized representative, request that health information regarding my care and treatment be disclosed as described on this form. I understand that:

1. I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
2. Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
3. Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP/CUIMC/WCM will not release your records.
4. By my specifically authorizing the release of sensitive information (i.e., HIV/AIDS related treatment, alcohol or drug treatment, mental health treatment information, and genetic testing information) that the recipient is prohibited from redisclosing 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 sensitive information, I may contact the New York State Division of Human Rights (844) 697-3471 or the New York City Commission of Human Rights at (718) 722-3131. These agencies are responsible for protecting my rights.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in Item 4 above) and redisclosure may no longer be protected by federal or state law.
6. I may revoke this authorization at any time by providing written notice to NYP/CUIMC/WCM except to the extent that action has already been taken based on this authorization.
7. I understand that this Authorization will expire on (enter date): ____/____/____ or 1 year after being signed.

Signature of Patient/Authorized Representative: ________________________ Date: ____/____/____

If Authorized Representative, please print name and relationship to patient and provide supporting documentation as appropriate:

Name: ________________________ Relationship:________________________