NewYork-Presbyterian
The University Hospital of Columbia and Cornell
43530

COLUMBIA | FERTILITY

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** ☐
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):

Outpatient/Physician's Office

☐ Columbia Doctors (outpatient/physician's office record only) please print your physician's name: Columbia University Fertility Center

Please specify reports/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) / /

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:

☐ E-mail, (encrypted)

The purpose(s) for which disclosure is authorized (check where applicable): ☐ Individual's request ☐ Medical Care ☐ Insurance ☐ Immunization ☐ Legal

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: _____ (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 _____