



43530

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): Hoosier Services Inc.			
Address (please print): 18032 Lemon Dr., #C-618, Yorba Linda, CA 92886			
Telephone (Area Code and Number): (800) 882-4156; Fax#800.882.4957; Email:service@hoosierservicesinc.com			
Check the name of the Center to disclose information or choose Other Healthcare Provider (specify): <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"/> 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) _____ <input type="checkbox"/> Hospital Admission <input type="checkbox"/> Emergency Department <input type="checkbox"/> Ambulatory Surgery <input type="checkbox"/> 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: <input type="checkbox"/> CD/DVD <input type="checkbox"/> 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			
Patient or Personal Representative Initial _____			
The purpose(s) for which disclosure is authorized (check where applicable): <input type="checkbox"/> Individual's request Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> Immunization <input type="checkbox"/> Legal <input checked="" type="checkbox"/> Other (specify): <u>insurance purpose</u> (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			

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

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