Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____

Street: _____ DOB: _____

City: _____ Phone: _____

State: _____ Zip: _____ Fax: _____

I authorize the release of the following health information:

- ☐ Initial Office Visit Consultation Note
- ☐ Pathology Reports
- ☐ Last Office Visit Follow-up Note
- ☐ Procedure Report
  - ☐ Colonoscopy
  - ☐ Upper GI Endoscopy
- ☐ Other:__ _____

Who will receive information:

- ☐ I would like the documents
  -OR-
- ☐ Send directly to my physician
  (Indicate their name & information→)

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

This authorization expires: ( ) when record is received or,
( ) other (explain)

_____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above
- I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I may revoke this authorization at any time before the information I have requested is released by notifying the Department of Urology at Weill Cornell Medical College in writing.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Weill Cornell Medical College shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements
- Weill Cornell Medical College may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment

_____ _____

Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print name Relationship to patient