Weill Cornell Medical College (WCMC)
Privacy Office
Forms

Authorization To Use or Disclose Health Information

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ Phone: _____

ST: _____ Zip: _____ NYP#: _____
(if available)

I authorize the release of the following health information:

- ☐ Entire medical record
- ☐ Diagnostic Tests Date(s): _____
- ☐ Doctor's Notes (from Dr. _____) Date(s): _____
- ☐ Lab Results Date(s): _____
- ☐ Pathology Reports ____ Specimens ____ Date(s): _____
- ☐ Radiology Reports ____ Images ____ Date(s): _____
- ☐ Medical Record/Information from outside the institution brought to the practice by me (explain): _____
- ☐ All of the above with the exception of: _____
- ☐ Other:_____

Who will release information: Name: _____
Address: _____
City, State, Zip: _____

Who will receive information: Name: _____
Address: _____
City, State, Zip: _____

This authorization expires: ( ) specific time frame _____, ( ) when record is received, ( ) other (explain) _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care
- I may revoke this authorization at any time before the information I have requested is released by completing a "Request to Revoke An Authorization" form, which is available at this office
- 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
- I may request a copy of this signed form
- 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

WMC, please indicate date completed: _____, retain this form in the patient's file, and provide a copy to the requestor