FAX: 646-962-0332

Weill Cornell Medicine

Authorization To Use or Disclose Protected Health Information (PHI)

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): _____
- ☐ Include Alcohol/Drug Treatment information (initial here) _____
- ☐ Include Mental Health information (initial here) _____
- ☐ Include HIV-Related information (initial here) _____
- ☐ 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/disclose information:
Name: WEILL CORNELL MEDICINE
Address: 1305 YORK AVENUE, 6TH FLOOR
City, State, Zip: NEW YORK, NY 10021

Who will receive information:
Name: _____
Address: _____
City, State, Zip: _____
Email: _____
CONFIRM EMAIL ADDRESS HERE: _____

Reason for Disclosure: _____

This authorization will expire when the record(s) is received by the authorized recipient indicated on this authorization.

I understand that:

- By signing this form, I am authorizing the use/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 by completing a "Request to Revoke an Authorization" form, which is available at Weill Cornell Medicine's Privacy Office. I understand that I may revoke this authorization except to the extent that action has been taken based on this authorization.
- 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/state law. Weill Cornell Medicine 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 Medicine 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