Authorization for Release of Medical Information (**Patient's Representative Version**) - Fillable Form

PATIENT INFORMATION

First Name* **MI** **Last Name*** **Date of Birth**

_____ ___ _____ _____

Maiden or Other Name **Medical Record Number**

_____ _____

Email* **Phone Number***

_____ _____

Mailing Address*

Address: _____

Address: _____

City:_____ **State**: ____ **Zip Code**: _____

REQUESTOR INFORMATION

First Name* **MI** **Last Name***

_____ ___ _____

Email* **Phone Number***

_____ _____

Mailing Address*

Address: _____

Address: _____

City:_____ **State**: ____ **Zip Code**: _____

SUPPORTING DOCUMENTATION

Your relationship to the Patient*

☐Parent/Foster Parent ☐Guardian

☐Medical Power of Attorney ☐Healthcare Proxy ☐Executor of Estate

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I Authorize*

Hospital/Inpatient

☐Wyckoff Heights Medical Center

Outpatient

☐Clinic ☐Diagnostic Testing Center

To disclose to*

☐Me or to ☐Named person or entity

A **fee** for medical record copied may apply. A patient whose records are copied and sent to another healthcare provider for the purposes of continuation of medical care **does not** pay a fee for medical record copies. Request for medical record copies for any use other than medical care may be subject to a fee. If a fee does apply, you will be notified prior to your request being processes. The HIPAA Privacy Rule permits healthcare providers to impose a reasonable, cost-based fee to an individual requesting a copy of medical records. The fee may only include the cost of labor, supplies and postage.

Name*

_____

Phone Number* **Fax**

_____ _____

Mailing Address*

Address: _____

Address: _____

City:_____ **State**: ____ **Zip Code**: _____

INFORMATION TO RELEASE

What to Release (check all that apply)*

☐Ambulatory Surgery Records
☐Clinic Records

☐Emergency Department Records
☐Inpatient Records

☐Abstract (free of cost)
☐Consult Report

☐COVID Testing Result
☐Discharge Summaries
☐Laboratory Reports
☐Operative Reports
☐Pathology Reports
☐Provider Notes
☐Radiology Reports
☐Other:

From Date* **To Date***

_____ _____

DISCLOSURE OF SENSITIVE INFORMATION

You have the right to refuse disclosure and prevent any other person from disclosing sensitive information related to the following conditions, treatments, or testing. **Include (indicate by checking below): Please note that the information will not be released if not checked.**

☐Mental Health Testing/Treatment (except psychotherapy notes)

☐Alcohol/Drug Treatment/Testing

☐HIV/AIDS Related Information

☐Genetic Testing Information

☐I authorize the disclosure of **ALL** sensitive information

☐I **DO NOT** authorize the disclosure of **ANY** sensitive information

Other Comments/Notes_____

Delivery Method

Release By*

Please choose the format to release the medical record. When possible, we will provide the information you requested electronically please check preference:

☐Receive electronic copy of records or email (secure)

☐Mail CD (if you choose this method there may be additional costs)

☐Fax

☐Connect to FollowMyHealth (Patient with active electronic medical record account can request electronic delivery via secure web patient portal at no cost.)

The purpose(s) for which disclosure is authorized (check where applicable):

☐Individual's Request

☐Continuation of Care

☐Insurance

☐Legal

☐Immunization

☐Other (specify)

Today's Date _____ Consent Expiration Date _____