Authorization for Release of Medical Information (**Attorney Version**) - Fillable Form

PATIENT INFORMATION

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

First Name Last Name Click or tap to enter a date.

Maiden or Other Name **Medical Record Number**

Maiden Or Other Name 0

Email* **Phone Number***

wyckoff@universe.com (XXX) XXX-XXXX

Mailing Address*

Address: Address line 1

Address: Address line 2

City: City **State**: State **Zip Code**: Zip Code

REQUESTOR INFORMATION

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

First Name Last Name

Email* **Phone Number*** **Fax Number**

wyckoff@universe.com (XXX) XXX-XXXX (XXX) XXX-XXXX

Organization Name*

Organization Name

Organization Mailing Address*

Address line 1 Suite Number (if applicable)

City: City **State**: State **Zip Code**: Zip Code

What party do you represent?* Case Number

☐Plaintiff ☐Defendant Enter your case number, or file number. You can reference this request by this number later.

Medical Facilities Requested

Facility or Provider*

Hospital/Inpatient

☐Wyckoff Height Medical Center

Outpatient

☐Clinic ☐Diagnostic Testing Center

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*

Click or tap to enter a date.

To Date*

Click or tap to enter a date.

SUPPORTING DOCUMENTATION

Please note*

This form will serve as the formal request for records from your firm. There is no need to submit a request on your firm's letterhead.

You will receive a copy of this submission via the email address that was provided. A **fee** may be charged consistent with the state rate guidelines for the reproduction of the medical records requested.

You must submit a fully executed Authorization form.

In addition, please be sure to include additional documentation to support the validation process such as Power of Attorney, Will, Proof of Guardianship, Death Certificate, or Letter of Representation.

File to upload (up to ## PDF files)*

Browse to choose file | Browse

Delivery Method*

Electronic delivery: You will receive an email, at the email address you provided, with a link to download the records electronically.

Additional Information

In the box below, please provide any additional information pertinent to this request.

Click or tap here to enter text.

Today's DateClick or tap to enter a date.

Review & Submit Request

Cancel my request for records

374 Stockholm St. Brooklyn, NY, 11237 ● Tel: (718) 963-7155 ● Fax: (718) 963-6664 ● Email: roi@wyckoffhospital.org