Authorization for Release of Medical Information (**Patient 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

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS

I Authorize*

Hospital/Inpatient

☐Wyckoff Height Medical Center

Outpatient

☐Diagnostic Testing Center- **371 Stockholm St**

☐Wyckoff Doctors-**1419 Myrtle Ave**

☐Pediatric Clinic-**1411 Myrtle Ave**

☐Wyckoff Medical Arts Building-**1610 Dekalb**

☐Women's Health Center- **110 Wyckoff Ave**

☐NEED THE NAME OF THE CLIINIC- **75-54 Metropolitan Ave**

☐ NEED THE NAME OF THE CLIINIC - **Hamilton Ave**

☐Other: Type the name/service of clinic-**374 Stockholm St**

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*

Name/Organization

Phone Number* **Fax**

(XXX) XXX-XXXX (XXX) XXX-XXXX

Mailing Address*

123 Elsewhere Lane

Suite 123

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***

Click or tap to enter a date. Click or tap to enter a 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 Click or tap here to enter text.

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 paper copy of records: ☐Mail ☐Pick-up

☐Receive electronic copy of records of email (secure)

☐CD (if you choose this method there is an additional cost): ☐Mail ☐Pick-up

☐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):

☐Patient's Request

☐Continuation of Care

☐Life Insurance

☐Legal

☐Disability

☐Worker's Comp

☐Other (specify)

Today's Date

Click or tap to enter a date.

Consent Expiration Date

Click or tap to enter a date.

Review & Submit for Signature

Cancel my request for records