



Date Received at the Clinic/Facility

Authorization for Release of Health Information Pursuant To HIPAA

| | | | |
|--|-------------|-----------------------------|-----------------------------|
| Section 1. PATIENT INFORMATION (PLEASE PRINT) | | Medical Record Number (MRN) | Date of Birth (MM/DD/YYYY): |
| LAST NAME: | FIRST NAME: | MIDDLE NAME: | |
| Name at the time of Treatment (if different than above): | | | |
| Street Address and Apt.# | | City & State | Zip Code |
| Telephone Number: | | Email (optional) | |

Section 2.a. I, or my authorized Representative authorize the release of my health information FROM:

All Montefiore Medical Center locations where you received care (All Hospital and All Clinics) (*if not, please check all that apply*)

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|---|--|
| <input type="checkbox"/> Montefiore Medical Center 111 East 210th Street, Bronx, NY 10467 | <input type="checkbox"/> Montefiore Westchester Square 2475 St. Raymond Ave., Bronx, NY 10461 |
| <input type="checkbox"/> Children's Hospital at Montefiore 3415 Bainbridge Avenue, Bronx, NY 10467 | <input type="checkbox"/> Montefiore Hutchinson Campus 1250 Water Place, Bronx, NY 10461 |
| <input type="checkbox"/> Montefiore Wakefield Campus 600 East 233rd street, Bronx, NY 10466 | <input type="checkbox"/> Montefiore Einstein Center for Children's Mental Health 1300 Water Place, Bronx, NY 10461 |
| <input type="checkbox"/> Jack D. Weiler Hospital 1825 Eastchester Road, Bronx, NY 10461 | |
| <input type="checkbox"/> Montefiore Clinic/Provider Office (<i>write the name of clinic /provider and address</i>) _____ | |

Section 2.b. I, or my authorized Representative authorize the release of my health information TO (check only ONE):

Self - if the name and address are the same as in section 1 check this box and go to section 3

Other: write the name and address of the Person/Entity to whom this information will be sent to: _____

Section 3. MEDICAL RECORDS TO BE RELEASED
(Medical records containing any of the special protected information must also be signed by the patient if they are a minor age 12 or older.)

Section 3.a. DATES OF SERVICE (REQUIRED): from ____/____/____ to ____/____/____

Section 3.b. PLEASE READ CAREFULLY: You must check only one of the three options below:

- **Option 1: ENTIRE MEDICAL RECORD**
- **Option 2: ABSTRACT OF MEDICAL RECORD**
- **Option 3: SPECIFIC INFORMATION ONLY and then check all boxes that apply within that section.**

| | | | | | | | | | | | |
|---|---|----------------------|-------------------|----------|----------|------------------|-------------|-------------------|-------------------|----------------------------|--|
| <p>Option 1: <input type="checkbox"/> ENTIRE MEDICAL RECORD</p> <p>Includes ALL notes, test results, radiology reports and other documentation for services and treatment obtained in the emergency department, hospital admission, ambulatory surgery, or clinic visits. <i>Excludes psychotherapy notes and images</i></p> <p><input type="checkbox"/> Please check here if you wish to obtain copies of images as part of the entire record</p> | <p>Option 2: <input type="checkbox"/> ABSTRACT OF MEDICAL RECORD</p> <p>May contain the following, as applicable to your <u>hospital</u> admission:</p> <table border="0"> <tr> <td>History and Physical</td> <td>Discharge Summary</td> </tr> <tr> <td>Consults</td> <td>ED Notes</td> </tr> <tr> <td>Operative Report</td> <td>Lab Results</td> </tr> <tr> <td>Pathology Reports</td> <td>Radiology Reports</td> </tr> <tr> <td>Diagnostic Testing Reports</td> <td></td> </tr> </table> | History and Physical | Discharge Summary | Consults | ED Notes | Operative Report | Lab Results | Pathology Reports | Radiology Reports | Diagnostic Testing Reports | |
| History and Physical | Discharge Summary | | | | | | | | | | |
| Consults | ED Notes | | | | | | | | | | |
| Operative Report | Lab Results | | | | | | | | | | |
| Pathology Reports | Radiology Reports | | | | | | | | | | |
| Diagnostic Testing Reports | | | | | | | | | | | |

Option 3: SPECIFIC INFORMATION Note: If you select Option 1 or 2, do not check any boxes in this section

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|---|---|--|--|---------------------------------------|---|--|--|---|--|--|--|---|---|---|--|---|--|---|--|---|---|---|---|---|---|--|--|--|--|--|--|--|--|
| <p>RECORDS / NOTES (check all that apply)</p> <table border="0"> <tr> <td><input type="checkbox"/> Emergency Dept Record</td> <td><input type="checkbox"/> Hospital Admission Record</td> </tr> <tr> <td><input type="checkbox"/> Ambulatory Surgery Record</td> <td><input type="checkbox"/> Clinic Visit</td> </tr> <tr> <td><input type="checkbox"/> History and Physical</td> <td><input type="checkbox"/> Consult Notes</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> Operative Report</td> </tr> <tr> <td><input type="checkbox"/> Immunization Record</td> <td><input type="checkbox"/> Medication List</td> </tr> <tr> <td><input type="checkbox"/> After Visit Summary</td> <td><input type="checkbox"/> Physical Therapy Records</td> </tr> <tr> <td><input type="checkbox"/> Occupational Therapy Records</td> <td><input type="checkbox"/> Speech Therapy</td> </tr> <tr> <td><input type="checkbox"/> Itemized Bill</td> <td><input type="checkbox"/> Other Notes: _____</td> </tr> </table> | <input type="checkbox"/> Emergency Dept Record | <input type="checkbox"/> Hospital Admission Record | <input type="checkbox"/> Ambulatory Surgery Record | <input type="checkbox"/> Clinic Visit | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consult Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Medication List | <input type="checkbox"/> After Visit Summary | <input type="checkbox"/> Physical Therapy Records | <input type="checkbox"/> Occupational Therapy Records | <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Itemized Bill | <input type="checkbox"/> Other Notes: _____ | <p>REPORT/ IMAGES (check all that apply)</p> <table border="0"> <tr> <td><input type="checkbox"/> Laboratory Reports</td> <td><input type="checkbox"/> Pathology Reports</td> </tr> <tr> <td><input type="checkbox"/> Echocardiogram/EKG</td> <td><input type="checkbox"/> Pulmonary Function Testing</td> </tr> <tr> <td><input type="checkbox"/> Cardiac Cath Reports</td> <td><input type="checkbox"/> Radiology Reports (x-rays)</td> </tr> <tr> <td><input type="checkbox"/> Cardiovascular Reports</td> <td><input type="checkbox"/> Ultrasound Reports</td> </tr> <tr> <td><input type="checkbox"/> Other Report: _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cardiac Cath Images</td> <td><input type="checkbox"/> Radiology Images (x-rays)</td> </tr> <tr> <td><input type="checkbox"/> Cardiovascular Images</td> <td><input type="checkbox"/> Ultrasound Images</td> </tr> <tr> <td><input type="checkbox"/> Other Images: _____</td> <td></td> </tr> </table> | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Echocardiogram/EKG | <input type="checkbox"/> Pulmonary Function Testing | <input type="checkbox"/> Cardiac Cath Reports | <input type="checkbox"/> Radiology Reports (x-rays) | <input type="checkbox"/> Cardiovascular Reports | <input type="checkbox"/> Ultrasound Reports | <input type="checkbox"/> Other Report: _____ | | <input type="checkbox"/> Cardiac Cath Images | <input type="checkbox"/> Radiology Images (x-rays) | <input type="checkbox"/> Cardiovascular Images | <input type="checkbox"/> Ultrasound Images | <input type="checkbox"/> Other Images: _____ | |
| <input type="checkbox"/> Emergency Dept Record | <input type="checkbox"/> Hospital Admission Record | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Ambulatory Surgery Record | <input type="checkbox"/> Clinic Visit | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consult Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Medication List | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> After Visit Summary | <input type="checkbox"/> Physical Therapy Records | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Occupational Therapy Records | <input type="checkbox"/> Speech Therapy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Itemized Bill | <input type="checkbox"/> Other Notes: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Echocardiogram/EKG | <input type="checkbox"/> Pulmonary Function Testing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cardiac Cath Reports | <input type="checkbox"/> Radiology Reports (x-rays) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cardiovascular Reports | <input type="checkbox"/> Ultrasound Reports | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other Report: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cardiac Cath Images | <input type="checkbox"/> Radiology Images (x-rays) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cardiovascular Images | <input type="checkbox"/> Ultrasound Images | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other Images: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Section 3.c. SPECIFY IF SPECIAL PROTECTED INFORMATION NEEDS TO BE INCLUDED - WRITE YOUR INITIALS for ALL that apply:
(records indicated below will **NOT** be released through this authorization unless applicable line is initialized)

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|-----------------------------------|---|
| ____ HIV/AIDS-Related Information | ____ Genetic Testing Information |
| ____ Alcohol / Drug Treatment | ____ Mental Health Information (except psychotherapy notes) |
| ____ Other: _____ | |

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| PATIENT NAME: _____ | MRN: _____ |
| Section 4. This information is to be used for the purpose of: <input type="checkbox"/> Personal <input type="checkbox"/> Continuing Treatment <input type="checkbox"/> Benefits <input type="checkbox"/> Other (please specify): _____ | |

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| Section 5. DELIVERY METHOD AND FORMAT OF DISCLOSURE (Please check one option): | | |
| <input type="checkbox"/> Mail Delivery Records will be mailed to the address listed in section 2.b Format: <input type="checkbox"/> Paper <input type="checkbox"/> CD/DVD <input type="checkbox"/> Other: _____ <i>Some images may be released in CD/DVD only</i> | <input type="checkbox"/> Pick-up Telephone number to be called when the records are ready for pickup: _____ Format: <input type="checkbox"/> Paper <input type="checkbox"/> CD/DVD <input type="checkbox"/> Other: _____ <i>Some images may be released in CD/DVD only</i> | Email check on one method and print email address <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Unencrypted* Email Email address (REQUIRED): _____ <i>*communication by unencrypted email presents a risk that personal identifiable information contained in the email may be intercepted by unauthorized third parties</i> <input type="checkbox"/> Montefiore MyChart Patient Portal (only with an active account at no cost) <i>Records will only be available for 30 days; you may print and/or save a copy for personal use). If you do not have a Montefiore MyChart you may sign up for an account by visiting https://mychart.montefiore.org</i> <i>If your record(s) cannot be delivered through MyChart, it will be mailed to the above-stated address on an encrypted portable media (e.g., CD/DVD)</i> |

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| Section 6. AUTHORIZATION EXPIRATION: I understand that this authorization will expire on this date or event _____ |
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| Section 7. REVIEW AND APPROVAL I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that: <ol style="list-style-type: none"> 1. I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below. 2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. 3. I have the right to revoke this authorization at any time by writing to the health care provider or entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. 4. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in the Special Protected Information section), and this redisclosure may no longer be protected by federal or state law. 5. I understand that I have the right to access my health information in the form and format requested if readily producible in such form and format, and that if my health information cannot be readily produced in the requested form and format, I will be provided with the health information in a form and format as mutually agreed upon. <p>I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or mental health treatment related information and/or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV). If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization.</p> <p>If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/ (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.</p> <p>All Items on this form have been completed and my questions about this form have been answered. By signing below, I acknowledge that I have read and accepted all the above.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Signature of patient or representative authorized by law _____ </div> <div style="width: 35%;"> Date _____ </div> </div> <p>If Authorized Representative, please print name and relationship to patients and provide supporting documentation as appropriate:</p> <p>Name: _____ Relationship: _____</p> |
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*Routine requests for medical records are generally processed within 10 days.
 To contact the Health Information Management Department, please call 718-920-4921.*

Please return completed form to: Montefiore, 111 E. 210th Street, Bronx, NY 10467 Attn: Medical Records (HIM)

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| FOR INTERNAL USE ONLY BY HEALTH INFORMATION MANAGEMENT (HIM) DEPARTMENT | |
| Campus where identification is verified: _____ | HIM Associate (print name): _____ |