Montefiore

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***)

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

_____

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.**

Option 1: ☐ **ENTIRE MEDICAL RECORD**
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.
Excludes psychotherapy notes and images

☐ ***Please check here if you wish to obtain copies of images as part of the entire record***

Option 2: ☐ **ABSTRACT OF MEDICAL RECORD**
May contain the following, as applicable to your hospital admission:

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

RECORDS / NOTES (check all that apply)

☐ Emergency Dept Record	☐ Hospital Admission Record
☐ Ambulatory Surgery Record	☐ Clinic Visit
☐ History and Physical	☐ Consult Notes
☐ Discharge Summary	☐ Operative Report
☐ Immunization Record	☐ Medication List
☐ After Visit Summary	☐ Physical Therapy Records
☐ Occupational Therapy Records	☐ Speech Therapy
☐ Itemized Bill	☐ Other Notes: _____

REPORT/ IMAGES (check all that apply)

☐ Laboratory Reports	☐ Pathology Reports
☐ Echocardiogram/EKG	☐ Pulmonary Function Testing
☐ Cardiac Cath Reports	☐ Radiology Reports (x-rays)
☐ Cardiovascular Reports	☐ Ultrasound Reports
☐ Other Report: _____	
☐ Cardiac Cath Images	☐ Radiology Images (x-rays)
☐ Cardiovascular Images	☐ Ultrasound Images
☐ 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)*

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

Montefiore

PATIENT NAME:	MRN:

Section 4. **This information is to be used for the purpose of:**

☐ Personal ☐ Continuing Treatment ☐ Benefits ☐ Other (please specify): _____

Section 5. **DELIVERY METHOD AND FORMAT OF DISCLOSURE (*Please check one option*):**

☐ **Mail Delivery**
Records will be mailed to the address listed in *section 2.b*

Format:
☐ Paper
☐ CD/DVD
☐ Other:
_____
Some images may be released in CD/DVD only

☐ **Pick-up**
Telephone number to be called when the records are ready for pickup:
_____

Format:
☐ Paper
☐ CD/DVD
☐ Other: _____
Some images may be released in CD/DVD only

Email check on one method and print email address
☐ **Encrypted** Email ☐ **Unencrypted*** Email
Email address (REQUIRED):
_____
**communication by unencrypted email presents a risk that personal identifiable information contained in the email may be intercepted by unauthorized third parties*

☐ **Montefiore MyChart Patient Portal** (only with an active account at no cost)
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

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)

Section 6. **AUTHORIZATION EXPIRATION:** *I understand that this authorization will expire on this date or event* _____

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:

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.

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.

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.

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.

_____ _____
Signature of patient or representative authorized by law Date

If Authorized Representative, please print name and relationship to patients and provide supporting documentation as appropriate:

Name:_____ Relationship: _____

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)

FOR INTERNAL USE ONLY BY HEALTH INFORMATION MANAGEMENT (HIM) DEPARTMENT

Campus where identification is verified: _____ HIM Associate (print name): _____