NYOBGYN of Mount Sinai

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234 East 85th Street, 3rd floor, NY, NY 10028 • Tel (212) 731-3232 • **Fax (212) 628-8530**
465 Ocean Parkway, Brooklyn, NY 11218 • Tel (718) 826-6179
101 Broadway, Suite BO2, Williamsburg, NY 11249
300 Cadman Plaza West, 17th fl, Brooklyn Heights, NY 11201
Email to: Nadia Sealy **medrecords85@gmail.com**

Authorization Form for Patient Records Release

The following must be completed for all authorizations.

<u>As we cannot guarantee delivery of records through the mail or by fax, we highly recommend that patients pick up their copies! Medical records will be available for pickup or will be sent out within 7 to 10 business days upon receipt of payment.</u>

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Federal privacy regulations.

I understand that I will be subject to a charge of seventy-five cents per page for my medical records, pursuant to New York State Law. If I require another set of records to be sent, I will be subject to the same charges. <u>If there are any charges for records, I will be notified first and medical records will be sent out within 7 to 10 business days upon receipt of payment.</u>

Patient Name (Please Print): _____ Date of Birth _____

Persons/Organizations Authorized to Release my Information:

NYOBGYN of Mount Sinai

Persons/Organizations Authorized to Receive my Information:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Which medical records would you like sent? Please be specific, or write "ALL".

_____

_____

Why do you need this information sent (Moving, changing doctors, to have own copy)?

_____

……

This Part For Office Use Only:

_____ CHARGE _____ NO CHARGE

Date Processed: _____ Charge Amount: _____

Prepared By: _____ Approved By: _____

_____ FAX _____ MAIL _____ PICK UP

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This Section Must Be Read and Signed by Patient or Patient's Representative

PLEASE INITIAL EACH OF THE FOLLOWING

_____ I understand that this authorization is good only for the medical records being requested currently. Any repeat sending or requests for records will need another request form.

_____ I understand that I may refuse to sign this form and that my healthcare and the payment for my healthcare will not be affected if I do not sign this form.

_____ I understand that I may request a copy of this form after I sign it.

_____ I understand that I may revoke this authorization at any time by notifying ***NYOBGYN of Mount Sinai*** in writing. If I do, the revocation will not have any effect on actions this practice has already taken in reliance on this authorization.

*** DUE TO THE VOLUME OF RECORDS REQUESTS RECEIVED, PLEASE ALLOW 7 to 10 BUSINESS DAYS FOR YOUR RECORDS TO BE AVAILABLE.

_____ _____

Signature of Patient or Patient's Representative Date

If Patient's Representative signs this authorization, please complete the following:

Name of Representative (please print) _____

Relationship to Patient (describe authority to sign on Patient's behalf)

_____