NewYork-Presbyterian
Lawrence Hospital

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Patient Name (please print):	Maiden or Other Name (please print):	Patient Date of Birth: / /
Patient Address (please print)		
Telephone (Area Code and Number): ( )	Email address (please print):	Medical Record Number:

Name, address and telephone number of Person(s) or Entity to whom this Information will be sent. Please check If same as above ☐
Send to (please print):

Address (please print):

Telephone (Area Code and Number):
( )

Check the name of the Center to disclose information or choose Other Healthcare Provider (specify):
☐NYP/Columbia University Medical Center (NYP/Allen Hospital; NYP/Morgan Stanley Children's Hospital) ☐NYP/Weill Cornell Medical Center
☐NYP/Westchester Division ☐NYP/Lower Manhattan ☐NYP/Lawrence Hospital
☐Other (Provide Name of Entity) _____
(please print)

Specify Information to be released (medical records will not be released unless a date of service(s) is identified on this form):
Medical Record from (insert date)_____ to (insert date) _____
☐Hospital Admission ☐Emergency Department ☐Ambulatory Surgery ☐Outpatient
Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.):

Include (Indicate by Initialing below): Please note that the information will not be released if not initialed.
_____Alcohol/Drug Treatment _____HIV/AIDS Related Information
_____Mental Health Treatment (except psychotherapy notes) _____Genetic Testing Information

Please consider the environment. When possible, NewYork-Presbyterian will provide the information you requested electronically please check preference:
☐CD/DVD ☐Electronic Delivery

Patients with an active NYP Lawrence patient-portal account can access certain medical record information via secure web patient portal at no cost. Please confirm and initial below:
- I have an active NYP Lawrence patient-portal account and understand that only certain medical record information may be accessed via the patient portal.
- If my medical record(s) cannot be delivered to NYP Lawrence patient-portal account it will be mailed to the above-stated address on CD/DVD

Patient or Personal Representative Initial _____

The purpose(s) for which disclosure is authorized (check where applicable): ☐Individual's request Medical Care ☐Insurance ☐Immunization ☐Legal
☐Other (specify): _____
(please print)

I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) be disclosed as described on this form. I understand that:
- I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
- Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
- Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP will not release your records.
- By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.
- I may revoke this authorization at any time by providing written notice to NYP except to the extent that action has already been taken based on this authorization.
- I understand that this Authorization will expire on: Date_____/_____/_____(provide date if less than 1 year) or 1 year after being signed.

_____ _____
Signature of Patient/personal representative (e.g., legal guardian) Date

_____
If personal representative, print name and relationship to patient

_____
Witness or Notary

NewYork-Presbyterian
Lawrence Hospital

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

MEDICAL CORRESPONDENCE UNITS			
SITE	**MAILING ADDRESS**	**IN PERSON ADDRESS**	**TELEPHONE NUMBER**
NewYork-Presbyterian Hospital / Columbia University Medical Center Morgan Stanley Children's Hospital of NewYork-Presbyterian Hospital (CHONY) The Allen Hospital (TAH)	622 West 168th Street Medical Correspondence Unit New York, NY 10032	177 Fort Washington Avenue Milstein Lobby New York, NY 10032	(212) 305-3270
NewYork-Presbyterian Hospital / Weill Cornell Medical Center	525 East 68th Street Medical Correspondence Unit Box 126 New York, NY 10065-4879	525 East 68th Street Room P-04 New York, NY 10065-4879	(212) 746-0530
NewYork-Presbyterian Hospital / Westchester Division	21 Bloomingdale Road Medical Correspondence Unit Hall H, Room 006 White Plains, NY 10605	21 Bloomingdale Road Main Lobby – See Security White Plains, NY 10605	(914) 997-5725
NewYork-Presbyterian Hospital / Lower Manhattan	170 William Street Medical Correspondence Unit Room M92 New York, NY 10038	170 William Street Room M92 New York, NY 10038	(212) 312-5121 and (212) 312-5122
NewYork-Presbyterian / Lawrence Hospital	Health Information Management Department Palmer Hall – 3rd Floor 55 Palmer Avenue Bronxville, NY 10708	Health Information Management Department Palmer Hall – 3rd Floor 55 Palmer Avenue Bronxville, NY 10708	(914) 787-3295