Request for Medical Records

DOWNTOWN WOMEN
OB-GYN ASSOCIATES, LLP

568 Broadway, Suite 304 – New York, NY 10012
Tel: 212-966-7600 Fax: 212-925-8736

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

(Note: This form cannot be used to authorize a release of HIV-related information.)

Patient Name: _____
Last First Middle

Home Address: _____

_____

_____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED:

☐ **Medical Records from ____/____/_____ to ____/____/_____**

☐ **Current OB Records**

☐ **Entire Medical Record**

RECIPIENT: * **Note**: We are only able to **email** or **mail** records. (No Faxes)

Name of person or class of persons to whom the Practice may disclose my health information:

_____

Email or Mailing
Address of recipient or where my health information should be delivered: _____

_____

TERM: This Authorization will remain in effect only from the date of this Authorization until the Practice fulfills this specific request.

By my signature below, I hereby authorize the Practice to use or disclose, to the recipient named above, my health information for the term of this Authorization as stated above.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I also understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Practice's Office Manager at the address listed above. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.
I understand that the Practice may charge a reasonable fee for materials and postage. Please allow 5-7 business days for processing.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, please complete the information below.

_____ _____ _____
Signature of Authorized Personal Representative Description of Authority Date

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV* RELATED INFORMATION

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

Name of person whose HIV related information will be released: _____

Name and address of person signing this form (if other than above): _____

Relationship to person whose HIV information will be released: _____

Name and address of person who will be given HIV related information: _____

_____

_____

Reason for release of HIV related information: _____

Time during which release is authorized: From: _____ To: _____

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

_____ _____

Date Patient Signature

New York State approved form 2557
February 1989