

T: 212-746-6000 <u>www.wcinyp.com</u> F: 646-962-0122
Please bring all completed forms to your appointment
(Office use)

MEDICAL RECORDS RELEASE FORM

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) & MEDICAL RECORDS

(Please	print clearly)				
Patien ⁻	t Name:				
Date o	f Birth:				
I here	by authorize Weill Cornell Imagii	ng at NewYork-Presb	yterian to	release my Protected	d Health Information
(PHI)*	from the following Date of Serv	ice:		_ in the event that th	e referring physiciar
or I re	quest that PHI, from Date of Serv	rice indicated, are to	be sent to	additional health care	e providers up to one
(1) ye	ar from the Date of Service.				
(OFFIC	E USE ONLY)				
MRN:					
ACCES *Multip	SSION (S)*:				
Staff I	nitial:				
рауте	Protected Health Information is ent for health care that can be link I or payment history.		_	• •	•
By sig	ning this document, I understand	that:			
2.	I may inspect or receive a copy of This authorization is voluntary at I may revoke this authorization at Notice of Privacy Practice. Such NewYork-Presbyterian in reliance This authorization will expire on My Protected Health Information physician or I request.	nd I have the right to at any time by providi revocation would not e to this authorizatio e (1) year from the D	refuse to ing a writto affect any n before ro ate of Serv	sign it. en notice of revocation action taken by Weill eceipt of my written re rice indicated above.	n as specified by the I Cornell Imaging at evocation.
X					
Signatu	ire of Patient or Personal Representative	Print Name if Represe	ntative	Relationship to Patient	Date