Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | 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)

Patient Name: _____

Date of Birth: _____

I hereby authorize Weill Cornell Imaging at NewYork-Presbyterian to release my Protected Health Information (PHI)* from the following Date of Service: _____ in the event that the referring physician or I request that PHI, from Date of Service indicated, are to be sent to additional health care providers up to one (1) year from the Date of Service.

(OFFICE USE ONLY)

MRN: _____

ACCESSION (S)*: _____ _____ _____
**Multiple accessions from same date of service only*

Staff Initial: _____

**PHI: Protected Health Information is any information pertaining to health status, provision of health care, or payment for health care that can be linked to a specific individual. This may include any part of a patient's medical record or payment history.*

By signing this document, I understand that:

1. I may inspect or receive a copy of the Protected Health Information described by this authorization.
2. This authorization is voluntary and I have the right to refuse to sign it.
3. I may revoke this authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice. Such revocation would not affect any action taken by Weill Cornell Imaging at NewYork-Presbyterian in reliance to this authorization before receipt of my written revocation.
4. This authorization will expire one (1) year from the Date of Service indicated above.
5. My Protected Health Information will only be sent to myself or to a health care provider that my referring physician or I request.

X_____ _____ _____ _____

Signature of Patient or Personal Representative *Print Name if Representative* *Relationship to Patient* *Date*