Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine
T: 212-746-6000 |www.wcinyp.com|F: 646-962-0122

MEDICAL RECORDS RELEASE FORM

(Office use only)

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

(Please print clearly)

Patient Name: _____ DOB: _____ Date: _____

Address: _____Phone#: _____

Please send the above-mentioned records to:

You can now view, share, and download your images through Connect. To enroll, please provide an email address.

- ☐ Connect: Email address: _____
- ☐ Myself, at the address listed above. *(For different address please fill out below).*
- ☐ I would like to request one complimentary CD. *(Please note, any additional CD will come at a cost of $25.00 per CD)*
- ☐ Additional Physician/Organization listed below. *(Your referring physician will automatically receive a copy of your results)*

Name/Organization: _____
Address: _____
Phone: _____ Fax: _____

Name/Organization: _____
Address: _____
Phone: _____ Fax: _____

I hereby authorize Weill Cornell Imaging at NewYork-Presbyterian to release the following Protected Health Information (PHI)* from my medical records in the event that a health care provider that the referring physician or I have requested, or I, should make a records request in the future up to one (1) year from the Date of Service.

*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 WCINYP in reliance to this Authorization before receipt of my written revocation.
4. This Authorization will expire on_____/_____/_____ (fill-in if less than 1 year) or 1 year after being signed.

X_____ _____ _____ _____

Signature of Patient or Personal Representative *Print name if representative* *Relationship to patient* *Date*

OFFICE USE ONLY:
Request Filled by:
Name (Print): _____
CWID: _____ Date: _____