Weill Cornell Medicine
NewYork-Presbyterian

Ophthalmology

1305 York Avenue
New York, NY 10021

Telephone: 646-962-2020
Fax: 646-962-0600
www.weillcornelleye.org

****Please allow 10 business days after forms are submitted for records to be received****

Authorization for Release of Medical Information

WEILL CORNELL MEDICINE

I hereby authorize the release of the medical record or medical information listed below by the Weill Cornell Medicine (WCM). I understand that the receiving party may not be subject to medical records privacy laws, and that the information could be subject to re-disclosure by the receiving party. In addition, Weill Cornell Medicine shall not be held liable to the patient or any other person for any consequences which result from disclosure of patient records. The provider may prepare a summary in lieu of allowing access to or copying of the entire record.

I understand that this authorization shall expire when the specified medical record/information is released by Cornell, and that if I want Cornell to release the information to any additional party or to release any additional information to the specified party I will need to fill out an additional authorization form. I also understand that I can revoke this authorization at any time before Cornell releases the information to the specified party by filling out and submitting to the Privacy Officer in writing a Revocation of Release of Medical Information Form, which I can obtain at this office on request.

Patient Information
Patient Name/ Name at Time of Service: _____
Patient's Address: _____
State: _____ Zip code: _____ Patient Daytime #: (___) ____-_____
Date of Birth: _____ SSN: _____

Name of Physician: _____
Specific/Exact Service Date(s): _____

Please release the following: (***Check all boxes that apply***)

- ☐ Ancillary/Lab Results
- ☐ Pathology Reports
- ☐ Doctor's Notes
- ☐ Diagnostic Reports
- ☐ Medical Record/Information from outside the institution brought to the practice by me

For all radiology notes/films please contact 212-746-2552.

The purpose of the information to be disclosed is at the request of a/an:
___ Patient ___Law firm ___Insurance Company ___Third Party Institution
Other_____

This section is for Weill Cornell Eye Associates employees only:
Patient MRN: _____ Date Processed: _____

Authorization for Release of Medical Information (continued)

WEILL CORNELL MEDICINE

Medical records requests are processed in the order in which they are received. The normal processing time for the request is ten business days. As a patient, I understand that there will be an administrative fee of $0.75/page for all **expedited requests**. Note: The medical record/information will only be released upon receipt of payment. Cornell accepts payment in the form of cash, personal check, traveler's check, and all major credit cards.

Method of Release

☐ **Pick up**:

I will pick up the medical record/information and agree to pay at time of pick-up, ***if necessary*** (please call the office to arrange specific time for pick-up at 646-962-2020)

☐ **Mail**:

Please send the medical record/information to:
Name: _____
Address:_____
_____
City, State, Zip Code: _____

☐ **Email**:

The "Authorization to Disclose Health Information via E-Mail" form must be completed and attached to this form.

☐ **Fax:** Attn: _____ fax number: _____

Signature: _____ Date: _____

Name and Relationship to patient if other than patient: _____

In case of a minor: (consent form must be signed by the parent or legal guardian and witness)

Signature of Parent or Legal Guardian: _____

Print Name of Parent of Legal Guardian: _____ Date: _____

Witnessed: _____ Date: _____

Retain original in chart
Provide a copy of the original to the requestor

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Privacy Office
Forms

Authorization to Disclose Health Information Via E-Mail

Patient Name: _____ MRN#: _____
Street: _____ DOB: _____
City: _____ ST: ____ Zip: _____ Phone: _____

This authorization covers protected health information (PHI) disclosed by Weill Cornell Medicine (WCM) personnel to a patient or a patient's representative through e-mail communication. It expires when the need to communicate via e-mail is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

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To be completed by patient or patient's representative:
My signature at the bottom of this form is authorization for WCM to disclose the health information of the above named patient via e-mail. It also confirms my understanding that:

- Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Re-disclosure may no longer be protected by law.
- I should not use e-mail for any urgent or time-sensitive medical questions or issues
- Once transmitted, I am responsible for safeguarding the information I receive
- I have the right to revoke this authorization at any time before information is disclosed by submitting to the Privacy Office a WCM Revocation of Release of Medical Information Form # PO012B. A revocation will not apply to information that has already been released as a result of this authorization
- To initiate e-mail communication, I will send an e-mail from my e-mail address, containing my request for information, to the WCM party at the e-mail address below
- I am responsible for notifying the WCM party listed below if my e-mail address changes and completing another authorization in order to communicate using a different address
- If I am communicating via e-mail about someone else, I attest that I am responsible for that person's care or payment and will indicate my relationship to the patient below
- WCM will not condition treatment or payment upon receipt of an authorization

For all medical records request, a *signed and completed* "Authorization for Release of Medical Information" form must be attached to fulfill your request.

The e-mail address I wish to use is: _____

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient

****

* To be completed by WCM:
Name of WCM party (please print): _____
WCM e-mail: _____
WCM, please indicate date completed: _____, retain a copy of this request in the patient's file, and provide a copy of the original to the requestor