

Authorization for Release of Medical Information

WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY

I hereby authorize the release of the medical record or medical information listed below by the Weill Medical College (WMC). 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 Medical College 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: _____ Patient Daytime #: (____)____ - _____
Name at Time of Service: _____
Patient's Address: _____ State: _____ Zip code: _____
Date of Birth: _____ SSN: _____
Insurance Carrier/Policy #: _____

Name of Provider: _____

Please release the following: (Check all that apply)

Ancillary/Lab Results Date: _____
Pathology Reports Date: _____
Doctor's Notes Date: _____
Radiology Reports Date: _____
Diagnostic Tests Date: _____

Medical Record/Information from outside the institution brought to the practice by me

All of the Above

All with the exception of: _____

The purpose of the information to be disclosed is:

____ At the request of the patient ____ Other _____

Authorization for Release of Medical Information (cont)

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I understand that there will be an administrative fee of \$0.75/page. The normal processing time for the request is ten business days. 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.

Authorization of Payment and Method of Release

I will pick up the medical record/information and agree to pay at time of pick-up (please call the office to arrange specific time for pick-up)

Please send the medical record/information to:

Name: _____

Address: _____

City, State, Zip Code: _____

Enclosed is my payment:

- Check (Make checks payable to : Department of _____
Division of _____)
- Credit Card Type: _____
- Name of Credit Card Holder: _____
- Credit Card #: _____
- Expiration Date: _____

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